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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
President, Harry J. Templeton, 3115 Webster Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland, 9.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, John H. Alexander, 2nd at Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Joseph W. Boomer, American Trust Building, Richmond.
Secretary, Henry W. McNerney, 2600 McDonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, John E. Young, Rowell Building, Fresno.
Secretary, K. D. Luechauer, 1759 Fulton Street, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Carl T. Wallace, Sixth and I Streets, Eureka.
Secretary, Joseph S. Woolford, 539 G Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Marian Hubbell, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, George D. Shultz, Lone Pine.
Secretary, Lloyd S. Bambauer, Bishop.
Meeting, *Fourth Wednesday, except December, January, February.*

Kern County Medical Society
President, Henry A. Rivin, 820 Tenth Avenue, Delano.
Secretary, Juliet Thorner, 109 Eighteenth Street, Bakersfield.
Meeting, *Third Thursday, 7:30 p. m., Motel Inn, Bakersfield, except June, July and August.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
President, J. Jay Crane, 418 South Arden Street, Los Angeles.
Secretary, E. T. Remmen, 429 North Orange, Glendale.
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Ralph Weseman, Novato.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
Secretary, Dale E. Barber, Fort Bragg.

Merced County Medical Society
President, E. R. Fountain, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Edwin Wiley Reeves, 605 Salinas National Bank Building, Salinas.
Secretary, Dixi M. Bingaman, Bank of America Building, Salinas.
Meeting, First Thursday.

Napa County Medical Society
President, Charles H. Bulson, 1203 Seminary Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Charles E. Irvin, 105 West Sycamore Street, Anaheim.
Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, George A. Foster, Grass Valley.
Secretary, Vernon W. Padgett, Grass Valley.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Omer W. Wheeler, 1939 La Cadena, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Maurice A. Hopkins, Route 7, Box 1246A, Sacramento.
Secretary, Edmund E. Simpson, 607 Garden Street, North Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, J. J. H. Smith, 137 East H Street, Colton.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, A. E. Moore, 2120 Fourth Avenue, San Diego 1.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street
President, G. Dan Delprat, 384 Post Street, San Francisco 8.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

San Joaquin County Medical Society
President, Yale Brody, Bank of America Building, Stockton 5.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton 2.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Erma B. Macomber, 1515 Broadway, Burlingame.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, George R. Luton, 103 E. Micheltorena Street, Santa Barbara.
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, Karl F. Pelkan, 903 Medico Building, San Jose.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Roy W. Thomas, 1726 Market Street, Redding.
Secretary, Clarence C. Gerrard, 1420 Market Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, H. Randall Madeley, P. O. Box 539, Vallejo.
Secretary, Charles H. Widenmann, 405 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William N. Makaroff, Guerneville.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Ralph E. Maxwell, 911 Thirteenth Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Charles Mathias, 215½ E. Kern Street, Tulare.
Secretary, James C. Malcolm, 1501 West Main, Visalia.

Ventura County Medical Society
President, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.
Secretary, George H. Arnold, Route 2, Box 12, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, William J. Blevins, Sr., 212 Porter Building, Woodland.
Secretary, Emery Leivera, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Joseph D. Lewis, 725 Fourth Street, Marysville.
Secretary, Thomas F. Keyes, 725 Fourth Street, Marysville.
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(For roster of C. M. A. committees and other organizations, see last month's issue)

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In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12. (Phone HIgate 7600.) 153 Kearny Street, San Francisco, 8. (Phone GArfield 0813.) 67 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles. (Phone DRexel 5261.)

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

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BOOK REVIEWS

BOOKS RECEIVED

The Art of Resuscitation. By Paluel J. Flagg, M.D., Chairman, Committee on Asphyxia, American Medical Association; President and Founder of the Society for the Prevention of Asphyxial Death, Inc.; Director of Pneumatology, New York World's Fair, 1939, Inc.; Author, "Art of Anaesthesia"; Visiting Anaesthetist, Manhattan Eye and Ear Hospital; Consulting Anaesthetist of St. Vincent's Hospital, The Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mount Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, St. Mary's Hospital, and Nassau Hospital. Cloth. Price, $5.00. Pp. 453, illustrated. New York: Reinhold Publishing Corporation, 1944.

Essays in the History of Medicine. Presented to Professor Arturo Castiglioni, on the occasion of his seventieth birthday, April 10, 1944. Paper. Price, $3.50. Pp. 358. Baltimore: The Johns Hopkins Press, 1944.

Samuel Brannan and the Golden Fleece. A Biography. By Reva Scott. Cloth. Price, $3.75. Pp. 462. New York: The MacMillan Company, 1944.

Annual Report of the Board of Regents of the Smithsonian Institution showing the Operations, Expenditures, and Condition of the Institution for the Year ended June 30, 1943. (Publication 3741). Cloth. Pp. 609. Washington: United States Government Printing Office, 1944.

Control of Pain in Childbirth—Anesthesia, Analgesia, Amnesia. By Clifford B. Lull, M.D., F.A.C.S., Clinical Professor of Obstetrics, Jefferson Medical College; Assistant Director, Philadelphia Lying-In Unit, Pennsylvania

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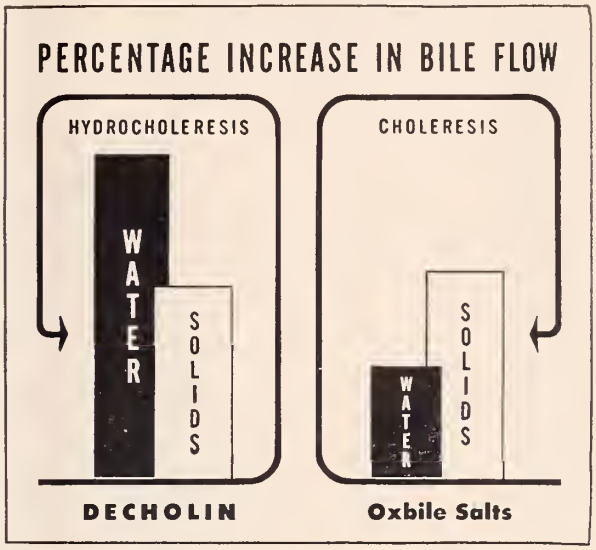
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BOOKS RECEIVED

(Continued from Page 7)

Hospital: and Robert A. Hingson, M.D., Surgeon, U. S. Public Health Service: Director, Post-graduate Medical Course, Philadelphia Lying-In Unit, Pennsylvania Hospital. With an introduction by Norris W. Vaux, M.D., Obstetrician-in-Chief, Philadelphia Lying-in Unit, Pennsylvania Hospital. Cloth. Price, $7.50. Pp. 356, with 100 illustrations in black and white and 32 subjects in color. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

Lead Poisoning. By Abraham Cantarow, M.D., Associate Professor of Medicine, Jefferson Medical College; Assistant Physician, Jefferson Hospital; Biochemist, Jefferson Hospital, Philadelphia, Pa. and Max Trumper, Ph.D., Lt. Commander, H-V(S), USNR, Naval Medical Research Institute, Bethesda, Md.; formerly Lecturer in Toxicology, Jefferson Medical College: Consultant in Industrial Toxicology, Cynwyd, Pa. Cloth. Price, $3.00. Pp. 264, illustrated. Baltimore: The Williams & Wilkins Company, 1944.

Arthritis and Allied Conditions. By Bernard I. Comroe, A.B., M.D., F.A.C.P., Associate in Medicine, University of Pennsylvania: Senior Ward Physician and Chief of the Arthritis Clinic, Hospital of the University of Pennsylvania. Third Edition, Enlarged and Thoroughly Revised. Cloth. Price, $12.00. Pp. 1359, illustrated with 329 engravings. Philadelphia: Lea & Febiger, 1944.

Handbook of Industrial Psychology. By May Smith. Cloth. Price, $5.00. Pp. 304. New York: Philosophical Library, 1944.

BOOK REVIEWS

Education and Health of the Partially Seeing Child. By Winifred Hathaway. Published for the National Society for the Prevention of Blindness, Inc. Cloth. Price, $2.50. Pp. 216, with illustrations. New York: Columbia University Press, 1943.

(Continued in Back Advertising Section, Page 30)

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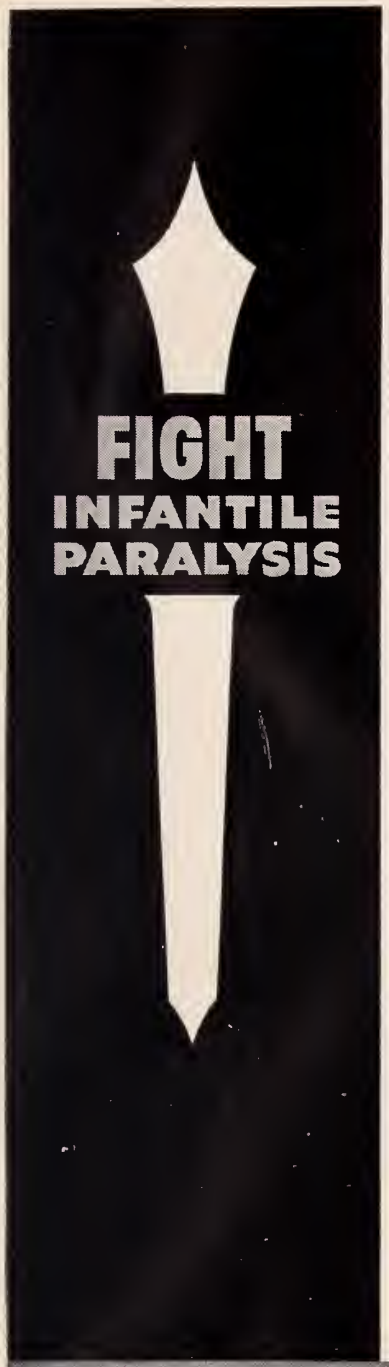
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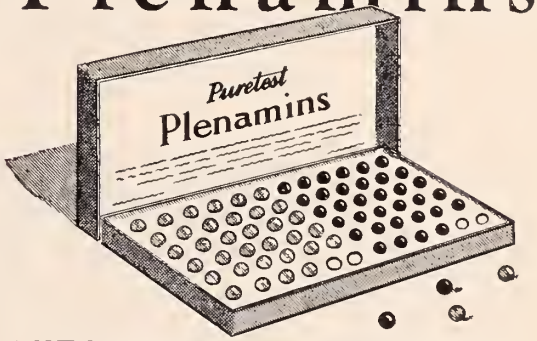
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1. Surg. Clinics of N. America, Feb., 1944. 2. J.A.M.A., *120*:265, 1942. 3. J. Lab. & Clin. Med., *28*:162, 1942. 4. J.A.M.A., *119*:615, 1942. 5. Med. Clinics of N. America, *27*:189, Jan., 1943.

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Arch. Otolaryng., 39:109-123, 1944.

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*Tripoli, C. J.: The Sulfonamides in Internal Medicine, New Orleans Med. and Sur. Jl., 96:455-461 (April) 1944

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

A COMPULSORY HEALTH INSURANCE LAW PROPOSED FOR CALIFORNIA!

Background of the Call for the Special Session of C.M.A. House of Delegates.—On December 2, 1944, Governor Earl Warren and State Director of Public Health Wilton L. Halverson visited C.M.A. Council Chairman Philip K. Gilman in Oak Knoll Naval Hospital, and at that conference Governor Warren told Captain Gilman he felt the time had come for the State of California to provide, through appropriate legislation, broader medical care, and also other protection against the catastrophes associated with illness, for all citizens of California who belong to the lower income groups.

Governor Warren told President-Elect Gilman he was presenting the subject to him that the matter, in turn, might be placed before the constituted authorities of the California Medical Association prior to the session of the Legislature which would convene on January 8. He also expressed his hope that the medical profession of the State would take an active interest in any medical care legislation that would be presented to the 56th California Legislature.

In reply, Council Chairman Gilman said he would promptly arrange for an informal conference at which Governor Warren could indicate to representatives of the California Medical Association his personal views on the subject of medical care for low income groups.

Accordingly, members of the C.M.A. Executive Committee held a meeting on the evening of December 12th at which time the nature of impending medical care legislation, insofar as information was available, received comment.

On the next day, Wednesday, December 13th, in San Francisco, Governor Warren spoke to officers and invited guests, and outlined further his own thoughts on the subject of adequate medical care. In this issue of CALIFORNIA AND WESTERN MEDICINE, on pages 25-40, appear minutes and memoranda bearing on the above and subsequent happenings. A perusal of the digest of Governor Warren's remarks, on page 27, will give C.M.A. members an insight concerning the problem that confronted the Association's Council, and the reasons that led the Councilors to unanimously vote to issue a call for the special

session of the House of Delegates of the California Medical Association, held subsequently in Los Angeles on January 4, 5, and 6. A letter from President Lowell S. Goin on December 20th was sent to every member of the Association. (See CALIFORNIA AND WESTERN MEDICINE, for December, on page 313.)

Since the subject of compulsory sickness insurance has many controversial phases, it is important that C.M.A. members take the time to read the minutes and other information above referred to, so that, in later exchanges of views and discussions, actual facts on what took place may be kept in mind. Through such perusal, useless argumentation, based on personal impressions or opinions, may be avoided.

* * *

Attitude of California's Governor.—It is important that all physicians keep in mind that the executive head of the California Commonwealth, Governor Earl Warren, expressed himself somewhat as follows:

The lower income groups of California citizens are entitled to adequate medical care; the State of California has an obligation to devise ways and means through which much medical care will be made available to these citizens; the trend of public opinion and effort is in favor of procedures to provide such medical care.

Governor Warren believes this obligation to provide adequate medical care should be promptly met; and from information he had received, he inferred that legislation designed to meet these objectives would be presented to the 1945 Legislature by Labor or other groups; also, he hoped the medical profession, as an interested party having major interests, would indicate the nature of its wishes and coöperation.

Further, in case the Legislature failed to enact proposed legislation, the Governor believed it was quite possible that interested groups other than the medical profession, through referendum-initiative would pass on to the electorate of California, the responsibility of decision on adoption of one or other medical care plans to be placed on the ballot of the next general election.

Governor Warren remained with the physicians who were present at the December 13th conference, listened to their criticisms concerning phases of some compulsory health insurance systems, and answered questions put to him.

After his departure, members of the Council continued their meeting, and the call for a special session of the C.M.A. House of Delegates, to be held in Los Angeles on Thursday, Friday, and Saturday, January 4-6, 1945, was one of the actions taken. The Official Call, outlining the purposes of the Special Session of the House of Delegates, printed in red ink on a stiff paper insert, appeared in the December issue of the Official Journal, opposite page 281, and is again given place in the current number on page 28.

Los Angeles Meeting of the C.M.A. House of Delegates.—Concerning the three-day session of the House of Delegates of the California Medical Association in Los Angeles, on January 4-6, the following may be stated:

Almost every component county society was represented by a full delegation, the absentees being largely from a few of the smaller county units;

The proceedings were marked by intense interest; and resolutions submitted, some thirty in number, as well as the many speeches and comments thereon, and the presentations by representatives of A. F. of L., C. I. O. and the Farm Bureau, all were given careful attention;

The open and executive meetings of the House and of the Resolutions Committee (both open to C.M.A. delegates and members), were carried on through the three days and nights, the Speaker endeavoring to give all delegates who desired to make comment, either for or against proposals submitted, full opportunity to do so;

The progress report of the Resolutions Committee, (consisting of H. W. Bosworth, Los Angeles, Chairman; Dwight H. Murray, Napa; J. J. Crane, Los Angeles; G. D. Delprat, San Francisco; and Walter Beckh, San Francisco), was submitted on Friday, and the revised report presented on Saturday received earnest discussion;

The final report of the Resolutions Committee, as amended, was adopted on Saturday afternoon, January 6th, and was immediately given to the press. This report appears in this issue on page 32.

* * *

Full Report of Proceedings Will Appear As a Separate Monograph.—Concerning the full proceedings of the House, these are now being transcribed by the stenotypist and secretaries. The C.M.A. Council has voted that the record of the proceedings be printed as a separate monograph, a copy to be sent under separate cover to every member of the California Medical Association. Envelopes will be suitably marked to indicate nature of contents, and members of the Association are requested to instruct their office assistants not to throw these reports into the waste basket. The future of medical practice in California, and, to lesser extent, perhaps even in the United States, depends upon full understanding and coöperation in the issues at stake. Therefore, the report of proceedings should be read by all C.M.A. members and placed in their files for future reference.

* * *

Press Reports on the Proceedings of the C.M.A. House of Delegates.—As was to be expected, the reports which appeared in California newspapers, and which were broadcast through the national press associations, were of varying nature. Particularly so, since Governor Warren, in addressing the California Legislature at its opening meeting on Monday, January 8th (two

days after the adjournment of the C.M.A. House of Delegates) brought medical care issues to the front, as may be noted in excerpts from his comments on "Prepaid Medical Service":

. . . "It is my recommendation that you [the California Legislature] take action at this session of the Legislature on a program which will bring adequate medical care to the people of our State, on a prepaid basis. . . .

. . . "I am convinced that if we are to keep abreast of needs in the services which we afford our people, we must start on this program immediately."

The section of Governor Warren's address to the Legislature relating to "Prepaid Medical Service," appears in this issue, on page 35. All C.M.A. members should take the time to read it, and if possible, also the other items bearing thereon. Better far, for physicians to have clear understanding and orientation from the beginning, than to engage in sharp criticism, misunderstanding and recrimination later on.

The Council of the California Medical Association solicits the prompt advice of component county units, and of all members, both in civilian practice and military service. Communications may be sent to individual Councilors or to the Association Secretary, at 450 Sutter Building, San Francisco (8).

* * *

What Is Ahead?—One guess is perhaps as good as another. For, who can tell in advance what the final result will be, depending as it does on the ballots of Assemblymen and State Senators, on so controversial a subject as compulsory health insurance?

According to press reports, Governor Warren will present a bill of his own.

In Los Angeles, before the C.M.A. House of Delegates, representatives of Labor (C.I.O.), stated they would present their own bill. Regarding this, see also in this issue, on pages 32 and 40.

Note may be made that it is possible the California Medical Association may deem it advisable to present a bill of its own, in which would be incorporated the principles and procedures espoused by its members, as understood by its officers.

If the Legislature, now in session, by May of this year, 1945, enacts one or the other of these medical care bills that will be submitted, or a composite thereof, such a measure then would be placed on Governor Warren's desk for approval or veto.

At the December 13th meeting, in answer to a direct question by a Councilor, Governor Warren stated if such a bill was presented to him, and its contents were not too vicious, he felt he would be obliged to attach his signature, giving approval.

However, the present 56th California Legislature can by-pass the proposed bills and through referendum, submit such a measure to the people, for electorate approval. Such approval would make the law partake of the nature of a constitutional amendment, with all the serious implications involved in constitutional amendments.

Or, the Legislature may take no action other than to appoint an Interim Committee of Senators and Assemblymen to study the entire subject, and bring to the next Legislature, two years hence, a report with perhaps, some recommendations.

Or, one or more of the groups submitting bills to the Legislature, may endeavor, independently, to secure the necessary signatures to place their respective measures on the ballot of the next general election of the State, in November, 1946, for direct initiative vote by the people.

* * *

From the above and what appears on this subject elsewhere in this issue, it should be apparent to all, that, during the coming weeks and months the officers and members of the California Medical Association will be called upon for much serious thinking and action. Let every member stand by his post and, when called on, lend a hand to render all possible aid to support that program and those plans that will insure to the citizens of California adequate medical service of highest quality. Physicians know better than others the conditions that make for high quality of medical service. On the issue of quality of medical service, there can be no compromise. Standards must be preserved and promoted, and plans that would make for lower types of service must be fought to the bitter end.

In conclusion, request is again made that all members read carefully the various items to which reference has been made above.

In due course, other statements and comments will follow.

Doctor Shortage Pays Off

In the past, when great battles were fought, loss of life was multiplied tenfold because of lack of prompt and adequate medical care for the wounded. But in the present war the story has been different. Even yet the full account of the achievements of medicine on "D-Day" has not been impressed upon the country.

One correspondent reports that within forty-five minutes after the first troops landed on the shores of France, a medical unit was on the beachhead picking up casualties, while in the background a landing craft was being converted into an operating theatre.

During the first day, twenty-two major operations were performed by this single unit. From dawn on "D-Day" until four o'clock in the afternoon, the unit remained on the beach. Blood plasma had been landed and transfusions made from mobile equipment.

Fifty thousand American doctors are in the armed forces. Everyone of them is a trained expert at the business of saving lives. At last those civilians who have had to linger in crowded waiting rooms to secure the attention of the overworked doctors on the home front, can see the reason for the inconvenience thrust upon them.—Oakland *Inter City Express.*

Life, to be worthy of a rational being, must always be in progression.

—Samuel Johnson, *Letter to Mrs. Piozzi.*

EDITORIAL COMMENT†

SEMLIKI FOREST VIRUS

During the course of a field investigation on the epidemiology of yellow fever, a hitherto unknown neurotropic virus was isolated from mosquitoes by Smithburn[1] and associates of the Yellow Fever Research Institute, Entebbe, Uganda.

About 130 female Aedes abnormalis mosquitoes caught in the Semliki Crown Forest were emulsified in 4 c.c. 10 per cent normal human serum and the emulsion filtered through a Seitz EK asbestos pad. Samples (0.03 c.c.) of the resulting filtrate were inoculated intracerebrally into 6 normal adult white mice. All mice remained well till the 27th day when one became paralyzed in the hind legs. This mouse was sacrificed and its brain used for intracerebral inoculation of a second group of 6 mice. All mice of the second group became ill on the 4th day. Four were then sacrificed for subinoculation tests. The other 2 died on the 7th day.

There were still greater increases in virulence on subsequent brain-to-brain passage. By the 160th passage the virus had become so virulent that it caused symptoms within 24 hours after intracerebral inoculation, death usually occurring within 48 hours. It was found that 5 to 20 intracerebral MLD of the passage virus were required to cause death by subcutaneous or intraabdominal inoculation, and from 1,000 to 10,000 MLD to cause death by intranasal instillation. By the 99th mouse passage the virus had acquired a demonstrable intracerebral pathogenicity for guinea pigs and rabbits, but was not sufficiently pathogenic to produce illness upon extraneural inoculation. By the 132nd mouse passage the virus had acquired a demonstrable intracerebral pathogenicity for rhesus monkeys, but was still nonpathogenic for monkeys if given by the subcutaneous route. Given extraneurally the virus stimulates the production of circulating antibodies in guinea pigs, rabbits and monkeys, as shown by serum protection tests on mice. Intracerebral pathogenicity and extraneural antigenicity were also demonstrated with 5 species of wild primates captured in neighboring regions of the Semliki Crown Forest.

The virus can be readily cultivated in the developing chick embryo, and suffers very little loss of potency if dehydrated in the Flosdorff-Mudd apparatus. Ultrafiltration experiments indicate that it is probably the smallest virus thus far discovered. Cross-neutralization tests with specific immune serums have shown that the virus is not identical with any known filterable virus thus far described, with the possible exception of that of Russian spring-summer encephalitis, not yet tested.

In mice injected intracerebrally the virus appears in the circulating blood in remarkably high concentration long before the onset of symptoms. In one titration of 5 pooled serums from mice still apparently well, 16,500,000 infective units per c.c. were demonstrated by intracerebral tests. After symptoms develop, the brain titer is usually at least 100 times that of the serum titer. The virus is also present in considerable quantities in the heart muscle, lungs, liver, spleen and all other tissues thus far tested. The titer is relatively high in the kidneys, suggesting that the virus is both neurotropic and nephrotropic.

The only constant macroscopic lesion seen at autopsy in mice, guinea pigs, rabbits or monkeys is hyperemia of the brain. In every brain thus far studied minute foci of necrosis and local infiltrations were found, lesions not unlike those described by Watson[2] in equine encephalomyelitis. Minor renal lesions were also present in most animals. All other visceral tissues escaped demonstrable injury.

Serums from 20 species of African wild animals have thus far been tested for the presence of specific antibodies. Humoral immunity was present in 24 of the 65 primates (6 different species) tested, but was not demonstrable in nonprimates. Serums from 313 human beings were similarly tested, 47 of whom gave positive reactions. The percentage of positive reactions varied from 7.9 per cent to 32 per cent in different regions, and was usually much higher in adults than in children.

It is not yet apparent that the natural virus causes recognizable illness in man or primates, nor that there are any objective sequelae other than specific antibody production. Mosquito transmission is suspected, though not yet fully established.

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Caius Julius Caesar (B. C. 100-44).—Historical verification that Caesar was an epileptic seems to rest upon the authority of Plutarch and Suetonius. Both speak of repeated attacks, one having occurred just before the battle of Thapsus. Whenever he felt an epileptic seizure coming on, Caesar would try to cover his face In the opinion of one writer the contemporary bust of Caesar quite plainly indicates the *Facies Epilepticus*, while another says that the inconography of Caesar proves the absence of facial anomalies.—Warner's *Calendar of Medical History.*

A man stricken with tuberculosis is just as much of a loss to the nation for whom he might otherwise be working or fighting as a man blasted with shrapnel.—Lt. Comdr. Emil Bogen, M.C., U.S.N.R., *Amer. Rev. Tbc.*

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

INDUSTRIAL MEDICINE IN WARTIME

FOREWORD AND FORWARD!

OR

THE WIDENING FIELD OF INDUSTRIAL MEDICINE*

RUTHERFORD T. JOHNSTONE, M. D.
Los Angeles

"REALLY, what have we here"! exclaims the Oldtimer, as he scans the contents of this particular number of the CALIFORNIA AND WESTERN MEDICINE; for, accustomed to the traditional character of his State Medical Journal, he wonders why Industrial Medicine rates this new recognition. Two or three years ago devoting an entire issue to this subject would not have been considered, reflects the Oldtimer, of whom there are many. Such ruminations are quite correct. However, the exigencies of war induced the publication of four special numbers devoted to wartime medicine, of which this is the last, but not the least important.

What do we have here? New names, new ideas, and different material. Part I has been especially designed to focus attention upon several aspects of Industrial Medicine, of which the profession at large, perhaps, is not fully cognizant or possibly even aware. Part II presents the modern treatment of some long-recognized problems. (For indexes, see pages 6 and 15.)

Actually the war has not altered greatly the practice of Industrial Medicine; its essentials remain unchanged. But the "brazen throat of war" served to proclaim the importance of this facet of medicine first given cognizance by Ramazinni 250 years ago. Today, industrial medicine has reached a level of utility second to no other branch of our profession. Lest there be some who will challenge that statement; who still stigmatize the industrial physician as a "finger-wrapper" or "insurance doctor"; who feel that the practice of industrial medicine requires no special training, and that it can be practiced indifferently with the left hand while the right is devoted to private practice, the following remarks, as well as the contents of this issue, may be illuminating.

Further reflection should make it apparent that there is an immediate need for the inclusion of the subject of Industrial Medicine within our undergraduate teaching, and in our postgraduate courses. Consider, if you will, the type of program presented each year by our county societies. Annually these are repetitious. The writer does not disclaim the importance of heart disease, diabetes, tuberculosis, arthritis, etc.; but the constant rehashing of these subjects, too often by the same speakers year in and year out, is at least discriminatory. This same criticism is applicable to the usual format of our medical periodicals. It is no longer possible for the general practitioner or specialist to escape contact with the occupational disease problem. It may be startling to some to learn that the occupational diseases constitute the largest number of diseases falling into any one subdivision of medicine. It is obligatory, therefore, that a knowledge of these be disseminated to the profession at large. It is even more essential that those preparing to practice medicine be taught about industrial medicine. It is imperative that our medical schools make room in the curriculum for the adequate teaching of this subject. The urgency awaits the vision and action of our professors.

Long ago Industrial Medicine outgrew its "Safety First" clothes. Preventing or treating the injuries—the traumata resulting from accidents—is now but one phase of an industrial practice. Since World War I new processes have been introduced into industry involving noxious solvents, fumes, dusts, and metals. Nor does there appear to be an end to the wizardry of the chemist or metallurgist when one contemplates the future of the synthetics, plastics and alloys. Few of these processes or the substances involved are free of some danger to the workmen unless adequate protection is supplied. Such protection can be found only in an efficient hygiene program which is one of industry's crying needs today. Medicine must supply industry with trained men and specialized laboratories for this purpose. An insight into this problem is presented in the article by Dr. Hugh Dierker and Paul Brown.

For too many years industrial management has employed a worker upon one basis only—his ability to work. No sensible attempt was made to assign a worker to a job according to his mental and physical capacities. Likewise, medicine has been guilty of consigning to the human scrapheap those who were physically handicapped; we were content with prescribing a sedative for the epileptic, idleness for the cardiac, or a prosthesis for the cripple. Rarely did a physician extend his interest to the point of securing suitable work for his patient. But Industrial Medicine has learned to utilize the handicapped individual, whether the deficiency be congenital or acquired, or as the result of a war wound. Dr. Kuh reveals how management and industrial medicine are matching job requirements with skill characteristics—matching physical demands with individual capacities. It is partcularly important to note that the selective-placement technique worked out by Dr. Kuh and his coworkers, is suitable for *all* workers and does not single out the handicapped person. This is a program to be participated in by the entire profession.

There are still other fields which Industrial Medicine encompasses, as the title of this comment intimates. With America's increasing interest in the social and economic welfare of its masses, it was inevitable that Industrial Medicine would be most intimately concerned. Well-meaning, politically-fostered plans to extend medical care have encouraged a goodly percentage of the people to demand federal medicine. It is this writer's considered opinion that Industrial Medicine offers the best buffer against socialized medicine as proposed by the Wagner Bill, or any subsequent facsimile thereof. It is this phase of medicine which deals most intimately with the very segment of our people, for whom better medical care is being demanded. That an employee, aided by his employer, can provide for himself and family adequate preventive and curative medicine is being demonstrated by many industries. Dr. A. C. Dick, Medical Director of Consolidated Vultee Aircraft Corporation, has given this problem a great deal of study, as shown by his able discussion in this issue.

Within industry there is the greatest opportunity for discovering tuberculosis in the incipient stage, as proved by the surveys conducted by the National Tuberculosis Association, the United States Public Health Association, and the California Tuberculosis Association. There exists an equal opportunity for a venereal disease program, or for a nationwide nutritional, dental, and mental hygiene program. There are still other frontiers, such as the early recognition and correction of defective hearing or vision; of the problems peculiar to old age or sex.

The limitation of editorial space forbids mention of

* One of several papers in a Symposium on "Industrial Medicine in Wartime—The Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M.D.

other worthy contributions to this special number. Suffice it to say that across the horizon of tomorrow awaits the opportunity for organized medicine to create a healthier America; to prevent the recurrence of the situation that found one out of four persons physically or mentally unfit. Since man spends his greatest span of years either in school or at work, the task of maintaining national optimum health must to a great degree be entrusted to industry and our schools. There is increasing evidence that Industrial Medicine is aware of its opportunity.

423 Towne Avenue.

PART I

The Interrelationships of Selective Placement and Rehabilitation	*Clifford Kuh, M.D., Permanente Foundation Hospital, Oakland*
How May a Worker Receive Adequate Medical Care?	*A. C. Dick, M.D., Medical Director, Consolidated Vultee, San Diego*
The Epileptic in Industry	*Wm. G. Lennox, M.D., Boston, Mass.*
Tuberculosis in Industry	*Howard W. Bosworth, M.D., Los Angeles*
Venereal Disease Control in Industry	*Harold T. Castberg, M.D., Chief Bureau of Industrial Health, California Department of Public Health*
The Place of Dentistry in Industry	*Hugo M. Kulstad, D.D.S., Hollywood, Member of the Council on Dental Health, American Dental Ass'n.*
The Use of Vitamin Supplements in Industry	*Howard W. Haggard, M.D., New Haven, Conn.*
Control of Toxic Exposures	*Hugh Dierker, M.D., and Paul G. Brown, Los Angeles*
Chart—Treatment of the Acute Occupational Intoxications	*Rutherford T. Johnstone, M.D., Los Angeles*
Treatment of More Common Industrial Injuries	*Table*

THE INTER-RELATIONSHIPS OF SELECTIVE PLACEMENT AND REHABILITATION*

Clifford Kuh, M. D.
Oakland

THE increased wartime need for maximal utilization of manpower has created great interest in proper selective placement at work and the forthright rehabilitation of those requiring it. There is, nevertheless, some confusion as to the respective fields covered by placement and rehabilitation, as such, and considerable misuse of terms.

Every worker needs correct placement at work in accordance with his skills and physical capacities. In fact, he needs much more than that. The International Labor Office's recent "Declaration of Philadelphia"[1] advocates that among the nations of the world there be the development of programs which will achieve "the employment of workers in the occupations in which they can have the satisfaction of giving the fullest measure of their skill and attainments, and make their greatest contribution to the common well-being." This point of view emphasizes the value of a selective placement technique which is suitable for *all* workers, and which does not, as some techniques do, single out handicapped persons.

Only handicapped persons require vocational rehabilitation, which may be defined as a service for creating or recreating earning capacity for all types of physically or mentally handicapped persons through vocational adjustment. Rehabilitation applies to those handicapped persons who cannot return to previous employment, or cannot readily be placed at other available work.[2] In some instances, rehabilitation aims to improve upon a disabled worker's previous earning power.

After a person has been vocationally rehabilitated he will require selective placement at work. To effect selective placement an evaluation of the physical capacities of any worker, disabled or fully able-bodied, is necessary. It is also necessary to evaluate the physical capacities of any prospective candidate for rehabilitation in order to determine whether he can return to former employment or to any other available job; whether the candidate's condition is relatively stable, and what the prognosis is. Since vocational rehabilitation requires time and expense, only those candidates should be recommended for rehabilitation whose probable length of employment or future earnings at the prospective work will justify the effort.

WHEN PHYSICAL EVALUATION IS NECESSARY

Evaluation of a worker's physical capacities in respect to a prospective job is, therefore, necessary (1) in originally placing any person at work or in transferring him from one job to another job within the organization; (2) in deciding whether a disabled person can return to a previous job or be placed on another suitable job and, if not, whether vocational rehabilitation for some new job is justified; (3) in planning a person's rehabilitation; and (4) in placing the individual after rehabilitation. Hence, a technique for evaluating the physical capacities of a worker is needed which can be related to the physical demands of a prospective job. Such a technique, known as *Physical Demands and Capacities Analysis*, has been developed at the Permanente Foundation Hospital in conjunction with the regional office of the War Manpower Commission in San Francisco, for the selective placement of Kaiser Shipyard workers at the time of transfer to new shipyard jobs. The technique has been described elsewhere.[3,4,5,6]

In brief, a physical capacities analysis of the worker evaluates what the worker can do in respect to a number of physical factors, such as lifting, carrying, pushing or pulling, and in respect to a number of environmental factors, such as working inside or outside, or working under high or low temperatures. The physical demands analysis of a job evaluates what the job requires in respect to the same physical factors and in respect to the same environmental factors. Hence, a common pattern is used for analyzing both worker and job.

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

From the Permanente Foundation Hospital.

The practicing physician, however, wants to know how much can the cardiac lift or under what environmental conditions can he work. Given any diagnosis, how can the physician translate clinical data in terms of physical capacities? That is a pertinent question. At the present time and until more is known concerning the relationship between clinical data and physical capacities, the physician's judgment is probably the best criterion. It is, nevertheless, progress to clarify the problem for, whenever a physician passes upon a man's ability to work at some job, whether the physician is aware of it or not, he is really translating clinical data into a physical capacities analysis.

Experience with the formal technique of physical demands and capacities analysis has found us relying on certain criteria. For example, in the placement of cardiacs the physical examination, electrocardiogram, chest x-ray for heart size, and past history in respect to arduousness of work, are all taken into account. Tabulation of criteria for guidance of staff physicians has been done for hypertensive heart disease, coronary arteriosclerotic heart disease, rheumatic heart disease, syphilitic aortic valvular disease, and congenital heart disease.[7] For rheumatic heart disease, for example, the following criteria apply:

A patient with rheumatic heart disease, because of the rheumatic diathesis, should also avoid wet quarters, sudden temperature changes, and perhaps the night shift.

Previous approaches to the problem of selective placement of handicapped persons at work have resulted chiefly in the preparation of lists of jobs which individuals with specific handicaps can perform, such as jobs for one-armed persons, or in classifications of handicapped people with reference to type of work to be done, as workers who must avoid hazardous machinery. Before these systematic approaches physicians usually recommended work in general terms, such as heavy, moderate, light, sedentary, or no work. Such statements were subject to broad interpretation and to misinterpretation. It is believed that from what has been said, the reader will agree the adoption of the identical pattern for analyzing both worker and job has decided advantages.

NATIONAL ADOPTION OF CAPACITIES ANALYSIS

There are already signs of the national adoption of the fundamental principle of employing the same pattern for analyzing worker and job as a selective placement technique. The Associated Industries of New York State have just published a pamphlet for member companies.[9] The American Mutual Alliance, representing companies engaged nationally in the field of casualty insurance, has published a similar treatise.[10] The Associaiton of Casualty and Surety Executives, representing stock companies, has recently issued a declaration of attitude on the employment of handicapped workers, affirming the philosophy that handicaps are of degree only—*who is without one?*—and that with proper placement nearly all handicaps to employment resolve themselves.[11]

The great interest in rehabilitation and placement means the more effective utilization nationally of all workers—male or female, young or old, emotionally stable or unstable, able-bodied or physically handicapped, and particularly the war disabled. Placement of the veteran, in the final analysis, does not present a problem different from the placement of any other person. His successful placement at work requires due regard for the physical demands of the job, and for the physical and emotional environment. A former machine gunner, who has suffered from an anxiety neurosis, should not be given a job next to a riveter. It is generally agreed, however, that we should not be unduly paternalistic in handling the veteran and that the most important single factor for insuring his employment with safety is selective placement.

Never before has there been such need for the physician to translate effectively clinical data into physical evaluation. Research will be needed to develop new techniques for assisting the physician in this work. There are already indications that such research will be forthcoming. It will be of great value in effecting the proper utilization of manpower.

SUMMARY

Only handicapped persons require vocational rehabilitation, but all persons require selective placement at work. Both rehabilitation and selective placement involve physical evaluation. The physician's rôle is to translate clinical data into physical capacities analysis.

Broadway and MacArthur Boulevard, West.

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WORK RECOMMENDATIONS FOR CARDIAC PATIENTS
With Rheumatic Heart Disease
(Illustrative of the Manner All Cardiac Patients Are Handled)

*Therapeutic Classification**	*Work Recommendations*
Class A Recovered case (Definite history but no diagnostic signs). Apical systolic murmur. No cardiac enlargement or abnormality of contour.	No Restrictions.
Class B Class I** (No symptoms on ordinary activity). Mitral stenosis with regular rhythm. Slight cardiac enlargement or left auricular prominence. (X-ray diagnosis readily made.) Right axix deviation by EKG.	50 per cent of Normal Activity.
Class C Class II (Symptoms on ordinary activity). Auricular fibrillation. Well developed mitral stenosis. Aortic stenosis. Moderate cardiac enlargement.	25 per cent of Normal Activity.
Class D Class III (Symptoms on less than ordinary activity). History of one failure (may be given special consideration if failure was due to active rheumatic myocarditis). Marked cardiac enlargement.	Sedentary Work
Class E Class IV (Symptoms at rest). Active rheumatic fever (as determined by resting apical rate over 100, persistent leucocytosis, anemia, rapid sedimentation rate, joint pains, or EKG evidence). Left ventricular strain. Aortic regurgitation with history of failure.	No Work.

* The therapeutic classification (A, B, C, D, and E) follows that of the American Heart Association.[8]
** Numerals represent the functional classification of the American Heart Association.[8]

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HOW MAY A WORKER RECEIVE ADEQUATE MEDICAL CARE?*

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IS it necessary to consider the problem of medical care for a worker as being different from that for other persons? A worker is a member of a community in the same sense as other members of his family or any other individual, whether or not he produces goods or services for which he receives pay from the management of a plant or facility. In this sense there is no reason for considering that medical care for a worker should differ from that available to other members of his community.

There are several factors, however, with which a worker must contend that do differentiate him from other members of his community. When he loses time from his job, through illness or injury, he loses income for himself and those who depend upon him. Furthermore, his absence from his job constitutes an economic loss to his employer. Thus, industry, as well as the community, has an interest in proper medical care for workers. For this reason, it is proper to consider medical care for workers as a specialized problem.

WHAT IS AVAILABLE?

What is available for a worker in the way of medical care? In a large factory or industry there is usually a management-controlled medical or first aid department for the care of occupational injuries and diseases. Rules and regulations promulgated by the insurance carriers and by the State agencies supervising industrial hygiene, tend to standardize the quality of care in a large industry to the acceptable minimum.

Under the supervision of an experienced full-time Industrial physician, the occupational hazards of workers are, as a rule, very well cared for. Because of the many factors involved in industrial medical care, a part-time physician cannot satisfactorily fulfill his obligation either to the worker or to management. If the industrial physician in a plant is there part time because he has several small industries to care for, and if this type of work is all he does, and if he has properly trained nurses on his staff, he can give the worker adequate occupational medical care.

The physician who is in private practice and merely "takes on a little industrial work" to supplement his income (and I know of not many who do so for any other reason) is a menace to Industrial Medicine, for his interest is not in it. He does not comprehend the problems of factory work, nor does he choose to soil either his clothes or his mind in the study of these problems, first-hand.

The proper care of occupational injuries and illnesses begins first with their prevention. Then there must be the proper first-treatment. Following this, the decision must be made whether or not the condition is occupational, then if it is compensable, then if time away from the job should be ordered or a transfer to a different job. Next, the proper time of return to work must be judged, and whether to the same or to a different job. An honest evaluation of disability must be made and finally a follow-up to ascertain the accuracy and effectiveness of diagnosis, treatment, disability evaluation, rehabilitation and proper placement. Analysis must be made of the circumstances surrounding the accident or illness, to the end that a repetition may be avoided. Records must be established and maintained for management, insurance carriers and state agencies, and these must be filed for reference until the Statute of Limitation expires.

Unless these minimum requirements for occupational conditions are observed, the worker is not receiving adequate industrial medical care. These things he must have, because he is not only a member of the community, but an economic factor in integrated production. Collectively, workers represent millions of man-hours, and when they are ill or injured, billions of dollars are lost to employees and management alike.

So far, we have discussed only the in-plant care for workers suffering occupational injuries or illnesses. Why this is a specialized job for a medical supervisor is obvious.

CARE OTHER THAN IN-PLANT SUPERVISION

What of the fact that 90 per cent or more of conditions which affect a worker's efficiency occur outside and away from the plant? Does this imply that the industrial physician should look beyond the plant to see that proper medical care is supplied the worker for nonoccupational conditions because of their effect upon his occupational efficiency? If he does so, he has the following choices:

1. To extend medical care through having a full-time staff employed by management take over complete medical supervision of the worker. This can be paid for by management, the worker, or both.

2. To extend this care still further to take in the worker's family, and thus achieve a maximum feeling of security from economic loss on the part of the worker.

3. To provide group insurance for workers so they may have partial reimbursement for loss of time and a freer choice of physician. There is one definite drawback to the average group insurance policy, in that most companies will pay bills rendered by any practitioner, whether an M. D. or otherwise, and there is justifiable doubt that this constitutes adequate medical care.

4. The industrial physician can utilize for his workers the services of such groups as the Blue Cross, the C. P. S., and others. This ideally should be supplemented by a personal knowledge on the part of the cooperating physicians outside of the plant of general conditions within the plant. Certainly, when these outside physicians suggest changes in conditions of work, these should be discussed first with the industrial physician.

5. The industrial physician can work out a policy with the reputable members of the regular local medical society for the care of all nonindustrial conditions which affect his workers' efficiency. These "outside" doctors will then constitute an extension of the plant medical staff, or the plant medical staff can be considered an extension of the community medical group specializing

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in in-plant medical care, and the two groups can work in harmony to the same end. Any form of group insurance can be utilized to assist in the payment for this service.

All of these and many more possible methods have been utilized. Some have been very successful, others not.

INDUSTRIAL MEDICINE AS A SPECIALTY

One thing, however, is certain. Industry has become so integrated, and rules, regulations, and laws concerning workers have become so fixed that the industrial worker is, and will continue to be, a specialized problem no matter what his status when he is away from industry.

Thus, it seems apparent—gnashing of teeth to the contrary notwithstanding—that the general practitioner who "takes on a little industrial work" and his brother who is a "part-time industrial man" are one with the dinosaurs and dodos.

Recent scandals, such as occurred in New York City when many doctors were removed from insurance company rôles for fraud, could have come about as a result of insufficient industrial medico-legal knowledge on the part of "part-time doctors," as well as from lack of scruples. No matter what the reason, such incidents will not be overlooked by the lay reformers who would regiment and control medical practice.

The medical profession must recognize Industrial Medicine as a very real specialty which has developed as a corollary to changing economic and social conditions.

The medical profession must develop and train specialists for this work, and accept the leadership in development of proper programs for the care of workers, or we will play directly into the hands of other factions whose whole interest is not the providing of good medicine.

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THE EPILEPTIC IN INDUSTRY*

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APPROXIMATELY a third of a million American men and women of working age are subject to seizures. Probably a quarter of a million of these are fully able to work, but, even in these man-power hungry days, many are deprived of this privilege and the nation is deprived of their labor. The reasons are two: Public prejudice and laws regarding compensation.

Statement that the great majority of noninstitutionalized epileptics are fully capable of productive work is supported by information concerning more than a thousand private or clinic patients who were questioned and examined by neurologists throughout the country.[1] Examination disclosed that the vital organs and the musculature of these patients were as sound as in any unselected sample of the population; approximately nine-tenths had normal muscular strength and control, and in only 9 per cent was there gross mental deterioration. At the time of examination only 21 per cent were listed as unable to work, and of these, 85 per cent blamed seizures for the disability. Of those who reported they were fully able to work, 88 per cent were employed at the time of the survey. As for occupations, 14 per cent of the men were clergymen, dentists, engineers, lawyers, teachers, or physicians. Most frequently-named occupations were salesmen, 14 per cent; farmers, 13 per cent; clerks, 10 per cent; laborers, 10 per cent; and mechanics, 6 per cent. Many patients were employed in positions in which a sudden loss of consciousness would endanger life or property.

For epileptics, as for healthy persons, the proportion of accidental fatalities which are occupational is a rough indication of the degree of danger in a given employment. Among industrial policy holders of the Metropolitan Life Insurance Company[2] only 24 per cent of deaths due to accident occurred when the workman was "on the job." The proportion was lowest (1.8 per cent) for clothing-workers, and rose progressively for waiters, shoe and cotton mill operators, store clerks, hotel servants, office assistants, automobile factory operators (the last 6 per cent), farm and unskilled laborers (22 per cent), mechanics (28 per cent), chauffeurs (44 per cent), structural iron workers (67 per cent) and, highest on the list, electric light and power linemen (86 per cent). The great majority of occupations should be open to epileptics if the person is fitted to the job, and if certain general needs are met.

WHAT IS NEEDED

1. The first need is for a better knowledge of epilepsy on the part of the public. Employers and fellow employees must understand that individual situations differ widely. Seizures vary in severity from a blinking of the eyelids to a generalized convulsion, and in frequency from once in a lifetime to many a day. Except for their occasional lapses of consciousness and muscular control, most epileptics are as normal as their well brothers or sisters, and usually more eager to work and prove their value. Seizures are less likely to occur when the person is working than when he is idle. Finally, the recent discovery of new methods of diagnosis and of nonsedative drug therapy has greatly increased the physician's ability to assess the seriousness of the case, and to rid the patient of seizures.

2. The second need is for open-eyed coöperation between employer, patient, and doctor. At present, the patient must conceal his malady, a need often frustrated by the 4-F draft classification. A disability, which is hidden from the employer, prevents proper placement or the taking of needed precautions.

3. A third, and immediate need, is the clarification of labor compensation laws. Apparently, there are no statistics which show that the accident rate for epileptics is higher than for nonepileptics. One competent authority believes that if the epileptic is properly placed, his accident rate is not abnormally high.[3] The Civil Service enrolls epileptics, if the condition is not severe and seizures are under medical control. Probably, epileptics have a better accident experience than alcoholics or the chronically careless. However, known epileptics are usually refused employment in industry because of the liability of the employer for any accident which may occur. As to whether the employer is liable for injury which arises out of the person's disability, and not out of his employment, court decisions have not been in agreement. It would seem that either the epileptic should be permitted to waive his rights to compensation for injuries resulting from a spontaneous seizure (a provision in the compensation laws of only two States), or else insurance companies (and hence industry and the public) should pay the increased costs, if any, for compensation of these (presumably) handicapped workers.

This problem of compensation applies to all physically-handicapped workmen and not simply to epileptics. The issue is sure to "come to a head" with the program for the rehabilitation of sick and wounded service men. The public will demand that these men have a chance for employment equal to that of the unwounded. The man, who has seizures as a result of brain injury, should have as good an opportunity for work as the man who has lost a

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hand or an eye. In 1940, epilepsy, next to dementia praecox, was the most frequent medical cause for discharge from the Army. War injuries will swell the numbers. Many State Bureaus of Rehabilitation are forbidden to aid in the training of epileptics on the grounds that they are unemployable. Let us hope that this foul idea will not seep into the plans for the rehabilitation of wounded service men

As discussed elsewhere,[1,4] an enlightened public is a prerequisite to an intelligent handling of this problem. The American Epilepsy League is a valuable agency in public education. Physicians need to be more acutely aware of recent advances in the study and treatment of seizures, and of the therapeutic value of keeping a patient at work.

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TUBERCULOSIS IN INDUSTRY*

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WHEN tuberculosis is not diagnosed until the patient is aware of symptoms severe enough to send him to the doctor, the disease is usually moderately or far advanced. Industrial surveys done through the use of miniature x-rays taken by the tuberculosis associations have proven that if tuberculosis is to be discovered in the early and most curable stages, it must be done through the use of mass surveys and routine x-rays of population.

There are two points to be considered in discussing tuberculosis as an industrial hazard. One must be exposed to an open case, and infected, in order to contract the disease, or working conditions must be such as to aggravate a preëxisting infection. In the first group are those who are working in health, such as hospital employees, who are exposed to tuberculosis, particularly in general hospitals where they are in contact with unrecognized cases and no precautions are taken to protect them. (Tuberculosis wards, while a recognized hazard, now use a strict technique). In the same group are those who are exposed in industry through fellow workmen who are open cases of tuberculosis. This is the most important group and by far the largest. The second group includes those who have had preëxisting disease, and work under conditions which aggravate this to the point of reactivation. (In such instances it is not the type of occupation *per se* which is apt to cause the reactivation, but rather the imposition of a long work day, a long work week, inadequate rest, and insufficient nourishment to sustain the required energy output. Statistics and experience reveal few instances where an occupational environment itself causes the onset of reactivation of tuberculosis.) Many of these cases could be prevented if physicians would use sputum cultures and better laboratory work as a criteria for permitting convalescent patients to return to work; or would show sufficient interest in each individual case to advise the worker and coöperate with his employer in the selection of a suitable occupation.

One possible means of eliminating tuberculosis would be to x-ray the entire population of a given area at yearly intervals for five years, at the same time isolating and treating all communicable cases. The general practitioner and the radiologist can do much toward this.

Paralleling the case-finding work done through x-rays in the induction centers, the tuberculosis associations throughout the country have been working in industries. X-ray units permitting both 4" x 5" and 35 millimeter photographs of the fluoroscopic images of chests have been mounted in trucks and taken into industrial plants and housing units where there were no plant x-rays available, and, as a demonstration project, thousands of workers have been filmed. Demonstrable evidence of pulmonary tuberculosis has been found in from 1 to 5 per cent in the individuals x-rayed by this method, the average running about 3 per cent in most places. About one-half of these were found, on follow-up, to be active cases. These same surveys have uncovered a high percentage of cardiac cases which were undiagnosed prior to this examination.

The policy has been to notify the employee that there are abnormal findings in his chest, and suggest that he consult a physician and arrange for a 14 x 17 film to be taken. The need for better diagnostic work has been shown with a large number of persons who, after receiving the letter advising them to go to their physician, did so and were told that there was nothing wrong, and then subsequent laboratory examinations of the sputum revealed tubercle bacilli! This would indicate that more thought should be given to the proper handling of these survey cases; that less indifference and better coöperation should be exhibited by the family physician, and that communicable cases should be isolated.

There were 56,178 deaths from tuberculosis in the United States in 1943, of which California furnished 3,878, and 7,869 new cases were reported, averaging two new cases for each death. With a high percentage of these cases occurring in industry, it will take the cooperation of the private physician, the plant medical department, the volunteer agencies, as well as the local and State health departments, before this hazard can be controlled. Industry and our schools afford an excellent opportunity for mass surveys which, if combined with a proper follow-up system, will greatly reduce the incidence of tuberculosis in America.

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VENEREAL DISEASE CONTROL IN INDUSTRY*

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AN industrial group presents an admirable opportunity for the control of communicable diseases in a substantial adult population. This is as true of the venereal diseases as it is of tuberculosis, smallpox, the common cold, or any other communicable disease.

The venereal disease problem in occupational groups is no greater than it is for the general public. Substantially, employed groups and their families represent, or rather are, the general public. Public health agencies have in the past directed their attentions to school groups because in such is an already prepared, homogeneous group to which mass case-finding surveys and educational programs can be applied. The same is true of an employee

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group in the approach to adults, and this fact is becoming increasingly appreciated by public health agencies.

The venereal diseases cannot be considered occupational or compensable diseases, except as medical and clinical personnel may contract them from handling patients. Industry, therefore, has little direct responsibility for their control, although it has a definite interest and stake in the problem. When it is realized that 90 per cent of all lost time in industry due to illness and injury is from non-occupational causes, and that venereal diseases will be found in about 3 per cent of the workers—in some racial groups the percentage may be as high as 10, 15, or 20 per cent—industry is concerned from the point of view of effect on production.

Many public-health agencies have, in the last few years, seized the opportunity which industry presents, and have conducted mass serological case-finding surveys among industrial workers. These have brought to light many latent syphilis cases, and a few acute cases, and have, therefore, proved their worth.

On a single survey it is worthwhile to find a number of cases among a group of employees; but from a preventive medical point of view much is left undone unless a continuing program is established. There is always a labor turnover and, especially at the present time this turnover is very great. In a very short time the results of the survey will mean nothing as an indication of the situation regarding venereal diseases in that particular plant population.

A CONTINUED PROGRAM NEEDED

A continuous program must be maintained by the plant medical service, and this can best be done by coöperation of the plant medical service with the community health agencies.

A program in an industrial plant involves:

1. Close coöperation with local and State venereal disease or health agencies;

2. Serological and other indicated examinations or tests to be made at the time of employment as a part of a preplacement physical examination;

3. Similar examinations and tests as a part of the periodic physical examination;

4. Refer the infected individual to a private physician or a public clinic for adequate treatment (time off should be allowed if necessary for the patient to go for treatment);

5. Report the cases found to the public health authorities for follow-up of possible contacts, to prevent further spread;

6. Careful follow-up of the individual case by the industrial medical department to assure adequate and consistent treatment;

7. Judicious supervision of placement of the patient undergoing treatment by the industrial medical department. (All employees who are found to have venereal diseases must not be discharged or refused employment).

8. Education of the workers on the venereal diseases by personal interview in the plant medical department, and also through an organized educational program.

This education should include knowledge on how the diseases are acquired, how they may be prevented, the effects of the diseases in early and late stages if treated or untreated, and the economic factors involved.

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Tuberculosis is not always a poor man's disease, but savings of a considerable amount which a few may possess at the beginning of their illness are expended in most instances long before the course of treatment is finished.—*The Modern Attack on Tuberculosis* by H. D. Chadwick, M.D., and A. S. Pope, M.D., 1942.

THE PLACE OF DENTISTRY IN INDUSTRY*

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DENTISTRY has long been aware of its inseparable part in the overall health service of the individual, and in order that it may assume its share of responsibility in the health field, it is first necessary that Medicine recognize the entire problem. This is particularly true of health service in industry, since such service is administered by the medical profession, and rightly so. However, until the present war, when the necessity of having every man, woman, and youth constantly on the job, very few industries utilized a dental program.

Until two years ago the American Dental Association assigned the problems of Industrial Dentistry to several committees, particularly the Economics Committee. However, at that time, under the Council on Dental Health, an Industrial Committee was established. It is composed of four dentists with knowledge or interest in industrial dentistry, and a consultant, Carl Peterson, M.D.. Secretary of the Council on Industrial Health of the American Medical Association. Last year, the chairman of this newly-formed committee was invited to attend the annual meeting of the Council on Industrial Health of the American Medical Association, in Chicago. This is a big step, and indicates the growing tendency to recognize Dentistry in our industrial health programs.

The justification for a dental program in industry is apparent. We know that most absenteeism is of nonoccupational origin. Also, the greater portion of both occupational and nonoccupational absenteeism is complicated and aggravated by dental disease. Estimates of percentages of those suffering from tooth infection, gum infection or both among adult employee groups, run from 65 to 95 per cent.

Whenever a complete health service, dental and medical, exists in an industry, conclusive proof is available to show that, by controlling dental infection, a material reduction in all lost time results. This experience should impress the industrial executive with the fact that an industrial dental program is an economic measure, and an important factor in efficient production.

In a recent study made by Dr. Ernest Sloman, Dean of the Dental School of the Physicians and Surgeons College, San Francisco, he has shown that, throughout the United States, dental care costs 26 cents of each dollar spent for health. It is hard to conceive any complete health care plan that could ignore these facts. If only 25 per cent of our people are getting dental care, and this is costing approximately 25 per cent of each dollar spent on health, how can a medical department in industry function without a dental department?

More emphasis must be placed upon oral hygiene in the preplacement (preëmployment) and periodic examinations of all workmen. Furthermore, it should be an efficient examination. Dental examinations made with tongue blades have been proven valueless. In fact, the dental profession now recognizes that the only worthwhile examination is one in which x-ray, mouth mirror, and probe have been used. Therefore, it follows that a dental division of the medical department must not only be manned by a dentist, but he must have proper equipment to function effectively.

An eastern war plant has undertaken a survey to establish the relationship of a good dental health program to the general health and efficiency of its workers, and the

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reduction of absenteeism. To date, the findings are astounding, and when the completed results are made public, they will serve further to emphasize that when Industrial Medicine includes Industrial Dentistry, then it may be truly designated as Industrial Health.

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THE USE OF VITAMIN SUPPLEMENTS IN INDUSTRY*

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THERE is today, among the leaders in the field of nutrition, general agreement that a considerable portion of our industrial workers are inadequately nourished for best health and mental and physical efficiency. Health and efficiency take on particular significance when industrial production is a critical factor in winning the war. Consequently, nutrition is often translated into terms of production. Certain leaders[1,2] in the field of nutrition believe that improvement in the nutritional status of industrial workers would, in time, result in increased production and efficiency, and diminished absenteeism, spoilage and accidents.

There is no doubt that dietary deficiencies exist, and that their correction would improve the health and vigor of many employees. But the direct translation of health and vigor into terms of production may not always be justified. Improvement in production from better nutrition has, as its premise, that the actual output of the individual worker is a valid measure of his capabilities. Good nutrition, however, does not compensate for bad management; and absenteeism due to poor morale is not corrected by vitamins.

In those plants in which the war effort is pursued to the full capability of the workers, nutritional improvement should have its effect on production, spoilage, accidents, and absenteeism. Even as small an increase in immediate production as one, two, or three per cent is significant,[3] and justifies any effort to obtain it.

The inadequacy of diet best recognized in the present state of knowledge as affecting industrial efficiency is that of certain vitamins. It would seem logical, therefore, as a wartime expedient, to make available to employees suitably-selected vitamin concentrates as dietary supplements. This seemingly logical practice, however, at once meets an opposition among the leaders in the field of nutrition as nearly concerted as the agreement of the need for better nutrition.[4,5] The weight of this authority has undoubtedly discouraged many industrial physicians from recommending such supplementation. In this connection, it is well to inquire as to the reasons for the opposition. Those given in published statements are mainly the following:

1. That the administration of concentrates is a form of therapy, and when given indiscriminately constitutes medical treatment without diagnosis. The fallacies of this argument are:

First, the nutritional inadequacies important in industry are mainly subclinical, and industrial conditions would prevent the routine and necessarily periodic use of individual diagnostic measures even if they were available —and they are not.

Second, that the use of supplements may be considered from the viewpoint of preventive medicine, as in the administration of table salt to workers in hot industries, a dietary correction which could also be made by altering the food habits of the employees.

2. That the promotion of vitamins is on a very low ethical plane and is, therefore, to be shunned by the reputable physician. The lack of ethics in some instances is certainly deplorable, but only the inhabitant of a scientific "ivory tower" would decline to join the war effort because the company was bad.

3. There are two cogent criticisms against the use of vitamin supplements, and both stem from the same philosophy. One of the most concise statements of these is that of L. H. Maynard[5]:

"While I would agree that the making available of synthetic vitamins to workers in war industries should be of some benefit in many instances, I do not favor such a program, mainly for two reasons. In the first place, it represents a very inadequate and incomplete nutritional program in terms of the needs of these workers. Second, it tends to over-emphasize the contribution to nutrition and health which can be made by a few vitamins, and to cause both management and workers to give less attention to the many other essential components of an adequate diet, with possible detrimental effects in terms of nutrition as a whole."

The industrial physician, faced with the problem of deciding whether or not the employees under his care should receive vitamin supplements, must make his decision as to whether the advantage of possible increase in production justifies the disadvantage of a possible delay in an educational effort. There are some who believe that winning the war on the production front justifies sacrifices even greater than the delay in education; there are others who believe that ultimate improvement is more advantageous than immediate production; and there are still others who believe that there is a middle ground in that the use of vitamin supplements and education are not mutually exclusive—that the supplements may be administered to correct possible existing deficiencies, and then curtailed and finally stopped as education progresses and reaches completion.

The present author is not as optimistic about the speed of this education as are many of the leaders in the field of nutrition who perhaps have had more laboratory than industrial experience. Education could have gone on before the war; it can go on during the war; and it should go on after the war. But it will be a slow progress at best and the important requirement now is winning the war.

The difficulties of education are perhaps no better summed up than in the situation of white bread. For a generation nutritionists have preached the advantages of whole wheat bread—but white bread continues in overwhelming public favor. Faced by the failure of education it was finally decided to fortify white bread with thiamin. Fortification is simply an euphemism for indiscriminate administration.

The wife of the industrial worker and the boarding-housekeeper have not, by and large, learned how to prepare a meal satisfying nutritional requirements or to prevent the loss of nutrients by standing, as on the steam table. Their education may be as slow as that of the public in favor of whole wheat bread, and it would seem equally justified to make up for the deficiency in the diet they supply by reinforcement—reinforcement in this instance by the administration of vitamin supplements to the employees.

There is another way of supplying certain vitamins—and one that is largely approved by many leaders in nutrition.[5] It consists in supplying a well-balanced meal in the factory cafeteria, and further reinforcing the food with one of the best sources of the vitamin B complex—brewer's yeast. This, in spite of the approval it has received, its general desirability and the fact that yeast is a

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natural food substance, is only another way of indiscriminate administration of vitamins—for which the present writer sees no need for euphemism.

At best, the industrial physician should not expect miracles of production from vitamin feeding. In an earlier paragraph, I have indicated the obstacles sometimes imposed by management and other factors. Experiment in determining the effects of such supplements can be made only under difficulties, and the results must be interpreted with caution. I have reported one such experiment[3] that unavoidably leaves much to be desired for complete scientific control. The results of six weeks of administration showed a moderate increase in production, a moderate decrease in absenteeism, and a marked decrease in spoilage. About half of the employees reported subjective improvement. In other plants where the nutrition level was higher or lower, the differences might be correspondingly smaller or greater. And in one where the morale of the employees and the policies of management were unsatisfactory, there might be no effect whatever except the subjective.

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CONTROL OF TOXIC EXPOSURES*

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BASICALLY, the prevention of occupational diseases is a problem of air hygiene. Of the three portals of entry of toxic substances,—namely, skin, digestive tract and respiratory tract,—the last is the one of major significance. It is true that the industrial dermatoses bulk largest in the occupational disease picture, and that some few substances may be absorbed through the skin to cause systemic poisoning. Further, in large-enough doses, some materials are absorbed in dangerous concentration from the digestive tract. But those toxic materials entering the respiratory tract in the form of dust, fume, mist, vapor or gas, are absorbed into the circulation in a disconcertingly efficient manner.

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Let us say that a concentration of 500 parts of carbon tetrachloride per million parts of air (maximum allowable concentration—100 PPM) is discovered by appropriate sampling methods in a given work-room atmosphere.

It then becomes necessary for a team of physicians, engineers and chemists to reduce the concentration to a safe level or to substitute a harmless chemical.

As in the treatment of patients, so in the management of a plant, the remedy must be suited to the individual problem. The method employed must be consistent with the production pattern, available materials, and a number of other considerations. However, there are basic principles which are applicable in all cases.

PRINCIPLES INVOLVED

The principles are as follows, in the order of their importance and practical application:

1. *Substitution* of a nontoxic or less toxic substance for the toxic one; e.g., the use of Stoddard's solvent rather than benzol in certain steps of rubber fabrication. This control measure is fool-proof. But production demands frequently preclude the application of this principle, and therefore we must resort to

2. *Isolation* of the process. This may be accomplished in one of three ways:

a. Geographically: by removing the process, from a shop where many workers are exposed to an isolated place on the grounds where few or no workers are exposed.

b. Chronologically: as in the case of some foundries, where it is the practice to have the small "shake-out" crews come in after the majority of the workers doing pouring and molding are gone for the day.

c. Enclosure: by actually building an enclosed space around the dangerous process and preventing the escape of noxious material into the workroom air.

Here again production demands may be such that they do not permit of such practices, and we must rely on

3. *Dilution* or *General Ventilation.* In other words, if 600 PPM of trichlorethylene are present in the worker's breathing atmosphere, and enough air can be brought in and thoroughly mixed at the breathing zone to dilute the concentration to a point below 200 PPM, the desired objective is accomplished. If it works, this is one of the best control procedures; but there are so many variables in the picture that it is usually more practical to install

4. *Local Exhaust Ventilation.* This is truly a subject in itself, and expert guidance must be sought to apply it in a practical and efficient manner. It is well known that exhaust orifices have no "reaching out" effect to entrap the material in question. The fact is, that only one duct diameter away from the orifice the velocity drops to 7

(Concluded on Page 24)

TABLE 1.—*Reference Chart Concerning Basic Exposures*

RESPIRATOR	HAZARD					DRAWBACKS
	DUST	FUMES	MISTS	VAPORS	GASES	
Dust (Filter)	*		*			Offer resistance to breathing.
Fume (Filter)		*				Offer resistance to breathing.
Chemical cartridge (Activated charcoal, etc.)				X	X	Low capacity. Rely on sense of smell as index to change cartridge.
Supplied air respirator (Face or helmet)	X	X	X	*	*	Cannot move around freely because of hose.
Gas mask with canister				X	X	Cumbersome. Use only in emergencies.
Oxygen breathing apparatus	X	X	X	X	X	Only for emergencies in which gas mask is inadequate.

* Most desirable. X Desirable.

NOTE:—Use only the makes of respirators which are approved by the U. S. Bureau of Mines.

TABLE 1.—*Treatment of the More Common Industrial Emergencies**

	Artificial respiration if oxygen not available	Oxygen and carbon dioxide, 5-7%, or see last column	*Respiratory Stimulants* Intravenous Coramine 5 c.c. Intravenous Metrazol 4.5 gr.	*Cardiac Stimulants* Coramine 1.5 c.c. intramuscularly Metrazol 1.5 gr. intramuscularly	*Sedation* *Never* morphine in this group! (Give Phenobarbital, Sodium Bromide, Chloral Hydrate Sodium Amytal, Paraldehyde, oral or rectal	High Carbohydrates	High Proteins	(a) Dextrose; (b) Glucose	(a) Diuretics—not mercurial except (b) Salyrgan for pulmonary edema	Blood transfusion (b) if preceded by venesection	Buffer salts for acidosis	Copious skin bath (a) Water; (b) Alcohol	Intravenous (slowly): 1% Sodium Nitrite. Give 50 c.c. in divided dose in one hour. Fortify with 5% Sodium Thiosulphate—50 c.c. *Don't* mix solutions	Calcium Gluconate intravenously	Sodium Chloride intravenously	Raise body temperature—Heat	Lower body temperature—Cold, ice packs, sheets, electric fan	*For Bronchial Asthma* Ephedrin Sulfate (Gr. ¾ q 4-6 hours Adrenalin 1:1000 1 c.c. Aminophyllin, Gr. ½ orally Aminophyllin, Gr. 7½ intravenously	*For Chemical Irritation to Eye* Eye lavage (a) Water; (b) Boric Acid; (c) Bland Boric Ointment; (d) Solution 0.5% Pontocaine Hydrochloride; (e) 2% Butyn or 4% Metacaine; (f) 2% Holocaine Hydrochloride; (g) Olive Oil	*Chemical Burns* (a) Bland Ointment (b) 2 parts glycerine, 1 part Magnesium Oxide; (c) wet dressing 20% Magnesium Oxide in glycerine	Soothing Nasal and Throat Spray	Atropine Sulphate 1/60 gr.	Acetyl B-methylcholine ***Avoid Epinephrine***	For bronchiolar spasm, 1 to 100 sol. Epinephrine by oral nebulizer. 100% oxygen under pressure
Carbon Monoxide	X	X														X								
Cyanide		X											X											
Carbon Tetrachloride		X			X	X	X	Xa	Xa						X									
Trichlorethylene	X	X	X		X			Xa																
Nitrabenzene					X	X	X	Xa		X		Xb												
Fluorine-Hydrogenfluoride		X	X		X			Xb							X						X			
Chlorine-Bromine		X		X																	X			
Hydrogen Sulfide	X	X	X								X										X			
Carbon Dioxide	X	X																			X			
Sulfur Dioxide		X	X	X	X																X			
Methyl Chloride	X	X	X		X			Xa			X										X			
Ammonia		X	X									Xa				X					X			
Methyl Alcohol				X	X			Xa			X													
Nitrogen Dioxide		X	X	X	X				Xb												X			
Phenol			X	X	X							Xb				X					X			
Gasoline-Naptha		X	X		X											X								
Cadmium fumes		X	X		X																X			
Phosphorus burns												Xa										Xa, d		
Heat Cramps														X										
Heat or Sun Stroke	X						Xa							X			X							
Electric Shock	X	X													X									X

PREPARED BY RUTHERFORD T. JOHNSTONE, M. D.

PART II

Sciatic Syndrome of Traumatic Origin	*Rupert B. Raney, M.D., Los Angeles*
New Concepts in the Therapy of Industrial Contact Dermatitis	*Nelson Paul Anderson, M.D., Los Angeles*
Emergency Treatment of Head Injuries	*W. J. Van Den Berg, M.D., Sacramento*
Industrial Urologic Injuries	*Alexander H. Peacock, Seattle*
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Industrial Treatment of Eye Injuries	*John N. Osburn, Los Angeles*
Burns	*J. C. Rooney, M.D., Santa Monica*

SCIATIC SYNDROME OF TRAUMATIC ORIGIN*

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A DISCUSSION of the sciatic syndrome requires clearer understanding of the phenomena covered by the term "sciatica." Such pain may result from disease of any of the nerve trunks supplying the lower extremities, or involving the spinal radices: for instance, spinal root compression from herniation of the nucleus pulposus in the lumbar region, neoplasm in the lower spinal canal, malignant or infectious disease of the pelvic organs. Pathognomic analysis reveals that the symptom of pain, seemingly identical in a number of diseases, varies considerably in character as well as in distribution, according to the difference of its traumatic origin.

HERNIATION OF THE NUCLEUS PULPOSUS

After rupturing through the annulus fibrosus, the nucleus pulposus tends to extrude until it reaches the proximal spinal root. Such contact produces pain in the area of the back supplied by the affected nerve, and pain referred to the lower extremities. In most cases a single spinal root is compressed, and the pain following the anatomic distribution of the nerve is never bilateral.

Infectious, or malignant diseases involve a number of nerve roots; the pain is generally centered in several body segments, widely distributed, as it is referred to the lower extremities, and tends to be bilateral.

Inconsequential back strains often prove the ultimate cause of posterior herniations of the nuecleus pulposus. Mostly, these lesions originate from the fourth or fifth lumbar interspace. As the fifth lumbar spinal root traverses the fourth lumbar interspace, and the first sacral spinal root the fifth lumbar interspace, the fifth lumbar and first sacral spinal roots respectively will be involved by such a lesion. Occasionally, they are encountered at higher levels, even in the cervical region whence the pain radiates into the upper extremities.

Diagnosis of herniation of the nucleus pulposus is based on certain well-defined neurological symptoms:

1. Tenderness to pressure over the affected interspace is common, often producing pain throughout the body segment supplied by the nerve whose root has been involved.

2. Limitation of the ability to raise the leg straight, on the affected side, combined with positive Lasègue's sign, will appear in most cases.

3. Careful search will always reveal at least minimal traces of local atrophy of the gluteal and calf muscles.

4. In almost half the cases sensory changes appear, consisting in impairment of sensibility to pain and temperature in the affected dermatome.

5. Scoliosis is common, especially in acute cases, tending to bend away from the side of lesion.

6. The Achilles tendon reflex is lost when herniation of the nucleus pulposus at the fifth lumbar interspace involves the first sacral spinal root. When the fifth lumbar spinal root is involved from herniation at the fourth lumbar interspace, the Achilles tendon reflex is ordinarily not affected, though occasionally slightly reduced.

The clinical diagnosis can, therefore, be based on objective as well as subjective symptomatology, especially on observation of character, distribution and changing intensity of pain. The main characteristic is anatomic distribution of pain, combined with evidence of impairment of nerve root function, apparent in atrophy of the gluteal and calf muscles. In impaired nerve-root function, contraction of these muscles reveals flaccidity in the gluteal cone and in the calf muscles. Frequently, fascicular twitching is observed in the area of atrophy.

Sensory changes restricted to the involved dermatome, pain caused by pressure upon the affected lumbar interspace, combined with the enumerated signs, are sufficient for a diagnosis of the lesion.

Laboratory tests have not proved especially helpful in arriving at a diagnosis. In more acute cases a slight increase in the overall protein content of the spinal fluid may be obtained, amounting to an average of 70 to 80 mg.; otherwise the spinal fluid shows no abnormal changes. But the rise in protein content is not diagnostic.

Myelography reveals herniation of the nucleus pulposus with a high degree of accuracy.

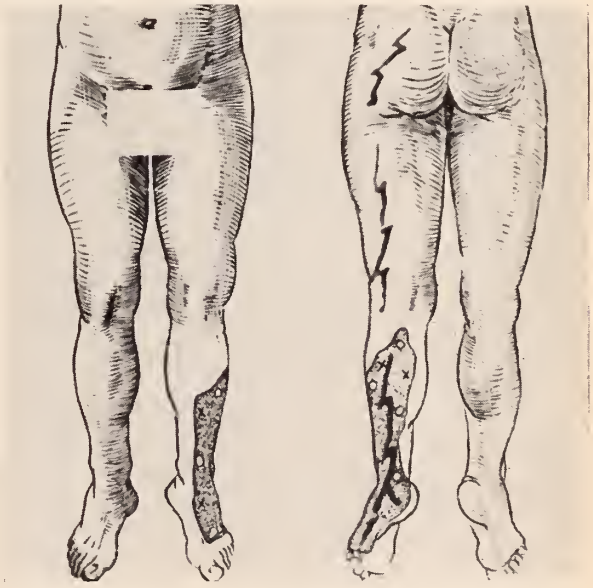


Fig. 1.—Jagged line and shaded area indicate general distribution of pain resulting from simultaneous compression of fifth lumbar and first sacral spinal roots, in ruptures of the intervertebral disk combined with herniation of the nucleus pulposus.

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.



Fig. 2.—Shaded area indicates zone of sensory loss encountered in compression of the fifth lumbar spinal root. Sensibility to pain and temperature is diminished, other forms of sensation within the zone remain unaffected.

Yet, this roentgenographic procedure should be restricted to cases in which not all clinical manifestations can be ascertained and, therefore, clinical diagnosis remains inconclusive. Inflammatory processes in the region of the spinal canal may be aggravated under influence of the available contrast media. Through careful clinical observation, such chronic inflammatory conditions may be recognized, as they differ clinically from the syndrome of ruptured intervertebral disk.

TRAUMA TO THE ANNULUS FIBROSUS

Trauma without extrusion of the disk occurs frequently, as a result of strain to the back. It gives rise to muscle spasm and scoliosis, and to local back pain, commonly known as "lumbago" or "sacro-iliac trouble." Pain is aggravated by coughing, sneezing and straining, and possesses all clinical features of herniation of the intervertebral disk, though it does not radiate to the lower extremities.

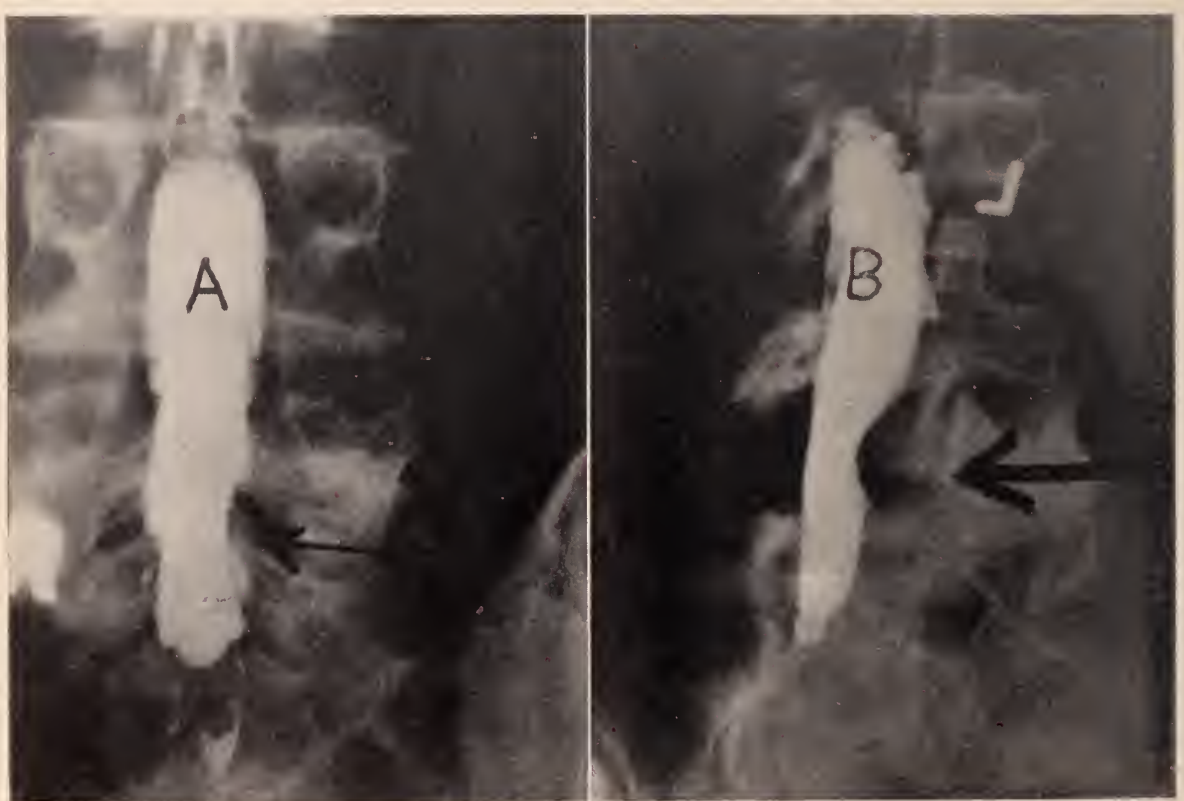


Fig. 3.—Filling defect demonstrating herniation of the nucleus pulposus: (a) arrow points to defect of axial nerve sheath pouch, produced by herniation of the nucleus pulposus from the fifth lumbar interspace; anterior—posterior view. (b) arrow points to defect in an oblique view.

INFLAMMATION AND PRESSURE FROM NEOPLASM

Infectious diseases of the spinal roots are less frequently encountered than commonly assumed. They are preceded and accompanied by low-grade febrile reaction, for which no adequate explanation can be found. Such infectious diseases implicate a number of spinal roots and nerve trunks, resulting in wide distribution of pain and bilateral involvement. The reflexes are affected to a considerable extent. Paresthesia is common and muscle tenderness almost always present. When diseases, like pelvic malignancy or pelvic infection, lead to the sciatic syndrome, it is not too difficult to arrive at a diagnosis, even though the patient may have suffered trauma prior to the onset of these symptoms.

Low-grade infection of the prostate, characterized by slight increase of cells in its secretions, is commonly held responsible for the syndrome of ruptured intervertebral disk, combined with spinal root compression. Yet, such a relation is coincidental, and infection of the prostate does not cause the syndrome of single spinal root lesion.

SUMMARY

The phenomena covered by indiscriminate use of the term "sciatica" should be carefully analyzed.

Herniation of the nucleus pulposus is one of the most common origins of recurring unilateral pain radiating into the lower extremities.

It derives frequently from recurring minor stresses to the back, especially when the structures involved are predisposed from congenital weakness, faulty posture, etc.

Characteristic clinical features of the ruptured intervertebral disk with herniation of the nucleus pulposus are analyzed.

Trauma to the annulus fibrosus, preceding spinal root compression through herniation of the nucleus pulposus, is described.

Low-grade infectious diseases, spinal neoplasms, etc., also cause pain, radiating into one or both extremities, but the clinical picture differs from that of herniation of the nucleus pulposus.

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NEW CONCEPTS IN THE THERAPY OF INDUSTRIAL CONTACT DERMATITIS*

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PHYSICIANS in industry, as well as physicians in general, have long been baffled or misled by such terms as allergy, sensitivity, and hypersensitivity. These terms have been widely used in the discussion of contact dermatitis, and in such a manner as to imply that they automatically explained the underlying process.

In two previous communications,[1,2] I have stressed the fact that most causes of industrial contact dermatitis are definite poisons. As such, these poisons can be neutralized by various antidotes.

The first step in dealing with a contact dermatitis is to determine the toxic irritant. This can be done by careful inquiry as to the industrial process in which exposure has occurred. Such a procedure should be followed by carefully-performed patch tests, in which care is taken to avoid the effects of primary irritation. The offending agent should then be tested as to its alkalinity or acidity, and for most substances litmus paper will give a satisfactory answer.

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

CHEMICAL NEUTRALIZATION

Direct chemical neutralization may be used. Thus a corrosive and irritant alkali can be neutralized by the use of a weak acid, such as acetic acid (vinegar) or citric acid (lemon juice), or even boric acid compresses. The following preparation was recommended by Reuter as a protection against alkaline solutions:

Rx—Lanolin	9.0
Stearic acid	50.0
Triethanolamine	2.70
Carbitol	18.0
Saturated solution of boric acid	120.0

Conversely the use of weak alkalies (sodium bicarbonate, sodium borate) is indicated in the neutralization of irritant acids.

DETOXIFICATION

A second valuable procedure is the use of detoxifying chemicals. These act on the irritating chemical to form either insoluble or nonirritating chemical compounds. Thus the dichromates can be detoxified by sodium or potassium bisulphite. Five per cent sodium hyposulphite is useful in neutralizing chromic acid. Paraphenylenediamine can be made less toxic by wet compresses of 10 to 15 per cent sodium thiosulphate. Dermatitis from tincture of iodine can be neutralized by wet dressings of 5 to 10 per cent sodium thiosulphate. Dermatitis due to fluorides should be helped by repeated applications of a paste made of glycerine or liquid paraffin and magnesium oxide, followed by wet dressings of 10 per cent calcium gluconate. Dermatitis due to formaldehyde should be helped by wet compresses of either (a) a solution containing 5 per cent urea and 1 per cent ammonium phosphate, or (b) a solution of 10 to 15 per cent of sodium or potassium sulphite, or sodium and potassium bisulphite, used either alone or incorporated into liquid soaps (potassium salts only).

Weak solution of copper sulphate (1 per cent) is of value in neutralizing various types of irritation from phosphorus compounds. Wet compresses of magnesium sulphate (10 to 15 per cent) should be of value in cases of contact irritation from barium salts. In contact dermatitis due to picric acid and the picrates (butesin picrate) a paste of magnesium carbonate, or alcohol, or a 3 per cent solution of lithium carbonate, or liquid soaps containing 5 to 10 per cent potassium sulphite, should be tried. Sodium thiosulphate (10 to 15 per cent), or weak acids should be tried in cyanide dermatitis.

Sodium bicarbonate alone, or in combination, is said to be effective in dermatitis from zinc chloride. Sulphonated oils are worth a trial in the prevention of cement dermatitis. Injuries to the skin from nitric acid may be alleviated by lavage with water, scrubbing the stained areas with methyl alcohol and liberal amounts of sodium bicarbonate. Finally, the yellow stain should be removed by a weak Dakin's solution. Weak alkalies should be of value in cases of dermatitis due to rubber, as from respirators, etc.

ADSORPTION

This third point of approach has been neglected in the treatment of external poisoning. Adsorption may be defined as a phenomenon of adhesion in an extremely thin layer of the molecules of gases, of dissolved substances, or of liquids, to the surfaces of solid bodies with which they come in contact. Such adsorbents are charcoal and kaolin. The former in various forms, e.g., wood, animal, and activated charcoals, has been widely used by chemical engineers, especially in removing noxious substances from drinking water. It is estimated that one cubic inch of charcoal possesses 20,000 square yards of adsorbing

surface; this property accounts for the use of similar substances in gas masks. Mercurial preparations and chlorinated hydrocarbons belong to a group of preparations which may be adsorbed by the following general antidote of McNally's, used externally:

Magnesium oxide		2 parts
Activated charcoal Tannic acid Purified Fuller's earth	aa	1 part

CLEANSING AND PROTECTIVE AGENTS

The unusual emulsifying and detergent properties of the newer synthetic wetting agents may be used to remove toxic chemicals from the skin, both in preventive therapy and perhaps in the therapy of the actual dermatitis itself The trade names of some of these wetting agents are: Duponol, Gardinol, Alkanol, Merpol, Avirol, Nekal, Naccanol, Aerosol, Decerosol, Santomerse, Igepon, Triton, Orthopol, and Tergitol. Due to their penetrating powers, they can also be used to carry neutralizing or detoxifying agents. Such preparations have already proved of great value in the prevention of systemic poisoning and contact dermatitis from T.N.T. and tetryl.

CONCLUSION

The chemical aspect of contact dermatitis in industry is worthy of study and investigation. There are no "shotgun" cures, and each problem demands considerable investigation before therapy is instituted.

2007 Wilshire Boulevard.

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EMERGENCY TREATMENT OF HEAD INJURIES*

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IN the treatment of head injuries there are established principles which, if followed carefully, will save many lives. The most important of these is close personal observation.

The extent of the initial brain injury should be determined at once, so that the physician may recognize and interpret any signs of increasing brain involvement, whether due to edema, hemorrhage, infection or softening.

Observe and record every thirty minutes the state of consciousness, pulse, respirations, blood pressure, temperature, size of pupils and response to light, muscle power of the arms and legs, and any reflex changes.

SIGNS OF INCREASING INTRACRANIAL PRESSURE

It is important to recognize signs of increasing intracranial pressure, particularly the early signs, and to combat them quickly. The state of consciousness is most important. Also, while compensation is present, the pulse and respirations will remain low and regular. The first signs of increasing intracranial pressure in a conscious patient is beginning stupor or sometimes restlessness. The pulse rate may drop to 50 per minute or lower, and the pulse pressure may increase. Restlessness may be a warning that coma is near, but it is sometimes due to a full bladder. Later, when compensation begins to break, the pulse rate increases, and becomes variable in rate and volume, the pulse pressure increases, the respirations become rapid, shallow and irregular, and the temperature rises.[1] With increasing intracranial pressure, the stupor deepens, delirium, convulsions, twitchings and spasticity appear, and Cheyne-Stokes respirations may develop.[2]

The treatment of shock is of primary importance and supersedes all other considerations. Place the patient in a warm bed between blankets in a semiprone position with head lowered, and apply heat. Clean out the air passages by suction or dependent drainage. Give 50 c.c. of 50 per cent sucrose intravenously, and follow with 500 c.c. or 5 per cent glucose. In severe shock give blood plasma or whole-blood transfusion.

TREATMENT OF INCREASING INTRACRANIAL PRESSURE

1. *Do a spinal tap,* measure the pressure, and remove at least 25 cc.'s. Make serological tests. Repeat spinal taps every 8 to 12 hours and remove at least 25 cc.'s of fluid if the pressure continues or increases. Repeated spinal taps to reduce intracranial pressure in the presence of an expanding extradural or subdural hemorrhage are not a substitute for an operation, but are actually harmful in postponing surgery.

2. *Dehydration:*

a. Limit fluid intake to an amount just sufficient for body metabolism—roughly 1,500 cc.'s.

b. Give hypertonic solutions intravenously—100 c.c.'s of 50 per cent sucrose. Excessive use of hypertonic solutions is harmful.

c. Obtain frequent liquid bowel movements by using four ounces of 50 per cent Magnesium Sulphate by rectum or Levine tube.

3. *Operation.* Consider this, if the patient is not responding to the above treatments. Subtemporal decompression is usually inadequate, but occasionally an unsuspected subdural hemorrhage or an hygroma is uncovered. It is much better to combine subtemporal decompression with a large flap, or use a bifrontal flap decompression.

Sedatives. Use phenobarbital or paraldehyde for sedation, but never morphine. Oversedation is dangerous.

Stimulants are sometimes necessary. Caffeine, coramine and metrazol are effective.

Nourishment should be maintained. Begin stomach feedings on the second day, if the patient is unconscious or won't eat. A daily fluid balance of 1,500 cc.'s to 2,000 cc.'s should be maintained.

X-rays should be taken only after the emergency stage, as they are seldom helpful. The fracture is important only if the brain is threatened, and we can ascertain this by inspection and palpation. The legal profession and the public still consider the fracture of the skull as the most serious injury, whereas the medical profession is concerned almost entirely with the injury to the brain.

REPAIR OF DAMAGE

If there is an open scalp wound, apply a tight, sterile bandage until shock is overcome. Then shave widely, wash with green soap and water, and apply antiseptic in an attempt to approach aseptic surgery. When the patient's condition warrants, debride the wound edges, remove dirt, discard dirty instruments, sift sulfanilamide powder into the wound and close without drainage. If a depression is beneath the laceration, the small pieces of bone are removed and the dura inspected for lacerations or the presence of a hemorrhage beneath. If a subdural hemorrhage is present, the dura is opened, the hemorrhage removed, bleeding vessels ligated, and the dura sutured with fine interrupted silk. If bony fragments or foreign bodies have been driven into the brain, these are removed, the macerated brain is removed by gentle irrigation and suction, sulfanilamide powder is sifted into

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the wound, and the dura is tightly sutured. Any dural defects may be closed by using a piece of adjacent periosteum. Slight depressions, unless compounded, may frequently be ignored.

Extradural and subdural hemorrhages should be operated upon as soon as the diagnosis is made. The usual signs are restlessness, advancing coma, dilatation of the pupil on the side of the hemorrhage, advancing paralysis of the face, arm and leg on the opposite side, together with signs of increasing intracranial pressure already mentioned. Frequently subdural hemorrhage does not materially affect the patient for days, weeks or months after the accident.

If there is a leakage of cerebral fluid from the ear or nose, these parts should never be sprayed or irrigated.

Major procedures for concurrent injuries, such as treatment of fractures, amputations, etc., should be delayed until recovery from the brain injury has taken place.

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INDUSTRIAL UROLOGIC INJURIES*

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INDUSTRIAL injuries to the genito-urinary tract involve primarily the kidney, bladder, urethra, and scrotal contents. Only occasionally does an industrial injury concern the ureter, prostate, seminal vesicles, vas deferans, penis, or foreskin.

RENAL INJURY

The kidney may be injured by a direct blow, compression of the abdominal contents, or falls from a height, resulting in a direct contusion to the kidney or from fractured ribs piercing the kidney. Falls upon the feet, or upon the buttocks, have caused tears to the kidney or capsule.

Type I—A tear of the true capsule with resulting hematoma.

Type II—Mild contusions of the parenchyma, without gross signs of injury, occur with the symptom of pain and the finding of microscopic red-blood cells.

Type III—Superficial tears of the parenchyma are not uncommon. They usually are transverse and irregular, and do not extend deeply into the kidney.

Type IV—Deep tears, pulpefaction, or severing of the renal artery or vein; these are the most serious of renal injuries.

Ninety per cent of all kidney injuries fall under Type III.

Renal tears may result in scars, cicatricial tissue, hydrocalyx, hydronephrosis, chronic renal infection, or extravasation of blood and urine in the perirenal tissues.

DIAGNOSIS

It is of the utmost importance to diagnose a renal injury early and determine its degree. The outstanding symptom is hematuria; this occurs in 90 per cent of cases, and it is usually early. The degree of the bleeding when present indicates the severity of injury; for example, a light staining, or merely microscopic blood cells, indicate a slight tear, provided the ureter is not plugged with a blood clot. Massive hematuria, a falling blood pressure, and shock point to a severe injury. Pain is usually present. It is often a typical renal colic with localized tenderness. As the hemorrhage progresses, a palpable tumor may form in the renal fossa. Accompanying this tumefaction is muscle spasm or rigidity.

Early in the picture there may be symptoms of shock. There may be no local evidence of hemorrhage and nothing to indicate it except hematuria. Patients who show signs of shock and/or hemorrhage bear the most critical watching. Half-hourly blood pressure readings are important in detecting a continuing hemorrhage. Fortunately clotting, intrarenal tension, and lowered blood pressure come to the patient's rescue. Many of the torn renal vessels are thus plugged with clots.

Excretory urograph is frequently, but not always, of value in determining the degree of injury. The affected organ may reveal an extravasation or show poor function. Due to shock, poor excretion of urine is the rule. Retrograde pyelograms are not usually recommended. Ureteral catheters and contrast media can readily displace a clot and further contribute to hemorrhage. Cystoscopy alone can easily add to the patient's shock. These examinations should be reserved until the patient is out of danger.

In summary, the diagnosis of renal injury is characterized by hematuria, unilateral renal pain, localized tenderness, muscle rigidity, and tumefaction.

TREATMENT

Treatment is readily divided into expectant and operative.

Conservative or Nonoperative Treatment.—As pointed out earlier, most kidney injuries fall into Types I, II, and III—tears of the capsule, contusions, and superficial tears. A mild hemorrhage takes place, clotting closes the open vessels, and absorption of the extravasated blood restores the kidney to its original form and condition. Therefore, in order not to disturb clotting, it is important to keep the patient perfectly quiet, and not to allow him to roll, twist, or bend the body. Warmth and blood plasma are often necessary for shock, and when there is hemorrhage blood, transfusion may also be needed. Often the pulse rate and blood pressure become well stabilized, and the patient goes on to a complete recovery. Again, it is best not to allow too much body movement until it is reasonably certain that all bleeding has been permanently checked. Ten days to two weeks of bed rest should be required after the last disappearance of the hematuria.

Operative Treatment.—Surgery is indicated when the hemorrhage persists or threatens the patient's life. Increased pulse rate, falling blood pressure, and severe pain are indications for exploration. The development of fever, chills, and tumor formation in the costovertebral angle, along with continued hematuria, may call for surgical intervention several days after the injury. It must also be realized that a tear of the renal artery or vein can quickly result in death. Most renal bleeding is arrested by normal clotting.

Suturing of severe kidney lacerations is not satisfactory, even with ribbon gut. Nephrectomy is much surer and safer, should the kidney be hopelessly torn. We have all seen cases where shock prevented immediate surgery or exploration, and the patient, after weeks of hospitalization, went on to recovery and restoration of function of the damaged organ. When surgery is necessary, it is good policy to wait until shock is over. Statistics show that operative treatment has a much higher mortality than conservative expectant treatment. On the

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

other hand, Lowsley states, "I believe it is conservative to operate early." After all, judgment and experience must be applied to each of these injuries of the urinary tract. There can be no hard and fast rules.

RUPTURE OF THE BLADDER

The two most common causes of this accident are direct blows to the abdomen with the bladder full, and crushing accidents to the pelvis, as in falls, the pelvis being caught between cars or heavy objects, etc. The latter can cause a springing apart of the public bones due to fractures through the sacrum, or a splintering of the rami and puncturing of the bladder with sharp bone splinters. These ruptures may be extra- or intraperitoneal; the latter, of course, being more serious. The symptoms usually develop early. Bleeding from the penis, voiding bloody urine, suprapubic pain, rigidity of the lower abdominal muscles, and shock are of frequent occurrence.

Diagnosis.—Early diagnosis is possible by air or contrast media cystograms, excretory urograms, or cystoscopy. The cystograms of air are preferable As the hours pass, pain and suprapubic tenderness increase. The abdominal muscles become splinted and board-like. The pulse rate goes up. Ecchymosis over the pubic bones, the scrotum, or perineum point to a severe injury. On the other hand, a case of intraperitoneal rupture of the bladder was seen a few years ago in which the abdomen was perfectly soft for three days. The patient voided clear urine, and yet died of peritonitis from a small rent in the dome of the bladder.

If the patient cannot void, and if a catheter cannot be passed to the bladder, it is evidence that the membranous urethra has been severed. The patient should attempt to void, and, if he cannot, catheterized specimen of urine should be examined for red blood cells. If there is any question of diagnosis, the condition should be treated as a potential rupture.

An indwelling urethral catheter may clear up the picture. At times, a contusion of the urethra, with mild bleeding, will be cleared up by such a catheter. A cystogram can be made at the same time.

Treatment.—Treatment of a ruptured bladder is most obviously one of early surgery. Hinman states: "Ruptured bladder is one of the few emergency urologic operations. It should be operated on within a few hours." All surgeons urge early cystotomy, for the mortality is high—25 to 45 per cent—and rapidly increases as the post-traumatic hours progress. Even with all our roentgenographic aids, it is not always possible to diagnose rupture of the bladder; so, when in doubt, operate if the patient is not in shock.

RUPTURE OF THE URETHRA

Rupture of the urethra occurs chiefly in crushing of the pubic arch and blows delivered to the perineum, as in straddle falls. The symptoms are bleeding from the meatus, inability to urinate, and inability to pass a catheter. There is usually the distress of an over-distended bladder, tenderness of the site of injury, and ecchymosis. As time elapses, edema takes place, and invasion of the scrotum or perineum with blood and urine occurs. Infection follows.

Treatment.—The only treatment is operative. There is the choice of suprapubic cystotomy, drawing a catheter through the severed urethra, or external urethrotomy. In the latter treatment, an attempt can be made to suture the severed urethral ends.

There are other industrial urologic injuries, such as those of the penis, scrotal contents, prostate, and vesicles. The more usual injuries, however, are the ones considered above.

It is emphasized that conservative treatment gives the best results with kidney injuries, and very early surgery is important in bladder or urethral ruptures.

1215 Fourth Avenue

THE TREATMENT OF SOFT-TISSUE INJURIES TO THE HAND*

IN INDUSTRY, the incidence of soft tissue injuries to the hand is alarmingly high. Since these injuries are extremely susceptible to infection, often leading to such complications as permanently-impaired function of the part, amputation, or even loss of life, their treatment is a major procedure. Especially is it imperative that the patient, with a severed nerve or tendon, be hurried to a hospital where the best surgical facilities are available. The repair of this type of laceration should be done within the first six hours following injury, for delay invites infection, and consequently prevents or retards healing.

In wounds where the time interval following injury has been longer than six hours, the decision as to operative procedure is influenced by certain factors. If the wound is greatly devitalized and obviously dirty, a simple dressing is applied without attempt at repair; or, if the delay has been longer than twenty-four hours, primary suturing of the nerves or tendons should not be done. On the other hand, primary suturing of the nerves or tendons can often be done after twelve hours, or even up to twenty-four hours if, at the time of injury, the first-aid treatment consisted of the implantation of sulfanilamide, and the application of sterile dressings, and if the wound appeared clean.

OPERATIVE PROCEDURE

Preparation of the extremity to be operated upon consists of shaving the area around the wound, and cleansing with soap and water. The entire extremity is then painted with equal parts of tincture of iodine and alcohol, save the wound itself, which has been covered with sterile gauze. The arm is elevated, sterile towels are wrapped about it, and an Esmarch bandage is applied. This bandage is wrapped about the extremity to a point one and one-half inches distal to the blood pressure cuff, which has been previously applied to the upper arm. The cuff is then inflated to 300 mm. of mercury pressure and both tubes clamped. (This type of tourniquet may be left on as long as one and one-half hours without injury to the nerves). The Esmarch bandage is then removed. Local, or block anesthesia, of 2 per cent novocain (or in prolonged cases, a general anesthesia) is administered. Adrenalin is never used in digital block anesthesia, because prolonged ischemia may result in necrosis. The wound is then sterilized with equal parts of iodine and alcohol, but the wound *should not be* washed out with saline, sterile water, or other solutions, as is frequently practiced. It is Boehler's opinion that solutions wash foreign particles deeper into the wound and only leave a false impression as to what constitutes surgical asepsis. It is now generally accepted that the technique of wound excision, as described by Boehler,[1] has reduced the incidence of infection in this type of injury.

* The author, being in military service, desires to remain anonymous.

One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

Complete excision of the wound is accomplished by beginning at one edge, removing approximately ⅛ of an inch in thickness across its base, including ⅛ of an inch of the skin border on the opposite side, but sparing tendons, blood vessels, and nerves. The ends of the injured nerves and tendons are cut off sharply, and soiled portions of bone are removed by means of a chisel or gouge. By this procedure, all the iodine is completely and systematically removed, as well as all particles of dirt and devitalized tissue. The potentially-infected wound thus becomes more nearly aseptic, and more nearly free of irritating chemicals. All remaining structure are potentially viable. After such an excision of the wound is accomplished, the instruments used are discarded and fresh drapes are applied. A new set of sterilized instruments is then brought into use.

Before removing the tourniquet, all structures that need repair, such as tendons and nerves, should be identified. After its removal the wound is covered with sterile gauze and manually compressed; bleeders are identified and tied off with triple "O" catgut, following which the operator is free to complete the suturing of all severed structures. Before describing this technique, it should be stated that nerves, bones, and joints should be covered, since these structures do not remain viable if left exposed. Skin flaps from adjacent areas may be utilized. Defects resulting from the transposition of these flaps may then be filled in with Thiersch skin grafts.

TENDON SUTURES

The ends of severed extensor tendons can, in most instances, best be approximated by means of No. 35 stainless steel wire, as advocated by Bunnell.[2] The double figure-of-eight suture is used, and the skin borders overlying the tendon are approximated by the continuation of this suture in the form of a mattress stitch through the skin. The skin borders of the remaining portion of the surgical incision are then approximated by intermittent mattress sutures of silk supported by a continuous running suture of No. 35 stainless steel wire. The use of stainless steel wire has been noted consistently to provide very little or no reaction, as compared to other materials. Sulfanilamide may be implanted in the wound before closure. Either tetanus toxoid or tetanus antitoxin is administered in all such injuries.

The flexor tendons, when severed, yield the poorest result, since they are enclosed in a tunnel-like sheath. Because of the firmness of this tunnel, the swelling following surgery impairs the blood supply and the structures may subsequently become ischemic or necrotic. The tendon may also become fixed by a firm scar, resulting in a stiff finger and loss of function. For this reason the sheath should be divided on its lateral surface. It is also preferable to use a suture material which produces the least reaction, as well as to approximate the severed tendon ends with as simple a stitch as possible.

Where flexor tendons of the fingers and hand are severed at the same level, it may be advisable to remove the flexor sublimus tendon, and suture only the flexor profundus. The latter can be accomplished by means of placing a wire suture through the proximal and distal portions of the tendon. This suture, in turn, is brought out through the tendon sheath and the skin at a point distal to the site of severance, and fixed by tying the knot over a small piece of rubber tubing, or to the nail of the involved digit. The pull-out wire passed through the proximal loop of the suture is brought out through the tendon sheath and skin. Likewise, this suture is fixed by tying it over a small piece of gauze, or rubber tubing, proximal to the site of repair. These sutures remain in place for a period of three to four weeks. If a pull-out wire is used, the entire suture can be removed from the tendon, after healing takes place. Should infection interrupt healing, the suture can be removed at any time. If stainless steel wire is not available, standard methods of suture can be carried out utilizing Deknatal No. 2 silk. If only the sublimus tendon is severed, it need not be sutured, since it is not essential for good function and only serves to balance the flexor mechanism of the finger.

NERVE REPAIR

Nerves are sutured with fine silk, using a small, straight needle. The severed ends are approximated by means of interrupted fine sutures taken at regular intervals about the circumference of the nerve sheath. Passing sutures through the nerve substance is avoided, and the approximated ends should never be under tension.

After completing the treatment of the wound in all its manifestations, it is advisable to elevate the injured extremity by means of an aeroplane splint until acute swelling has subsided. This relieves compression of tissue, especially nerves and blood vessels, by gravity edema. It also decreases pain and hastens recovery.

REFERENCES

1. Boehler, L., The Treatment of Fractures, John Wright and Sons (Bristol), 4th Ed., 1935.
2. Bunnell, S., Treatment of Tendons in Compound Injuries of the Hand, J. Bone and J. Surg., 23:240, 1941.

HAND FRACTURES IN INDUSTRY*

C. C. Cutting, M. D.
Oakland

THE HAND, a tremendously important organ to any workman, is subject to a high incidence of injury, and deserves a great proportion of industrial medical attention. Because of the extreme importance that all possible function be restored after an injury to the hand, even small and apparently insignificant injuries must be respected, and receive careful and intelligent care. Lacerations and contused wounds, even though apparently minimal in extent, may communicate with tendon sheaths, joint spaces, or closed compartments which have poor tissue resistance to infection, but infections of which may lead to severe disability. Early definitive care is imperative, and should include immaculate cleansing with soap and water, thorough debridement, local sulfonamide application, closure without drainage, and adequate immobilization.

Fractures of the skeletal structures of the hand present a particularly serious problem, since they may lead not only to deformity of the bony structure, but their close proximity to tendons and joints may markedly limit the function of these structures as well.

FRACTURES OF THE TERMINAL PHALANGES

Fractures of the terminal phalanges occur more frequently than fractures of any other bones of the body. Fortunately, there is little tendency toward separation of the fragments, and disability from this injury is rare. Immobilization for two weeks by a protective metal finger splint will usually be sufficient. Compounded fractures of the terminal phalanges may shatter the bone and the removal of separated fragments should be in-

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

cluded in the debridement. Removal of sufficient bone to allow a well-padded, soft-tissue flap on the end of the bone is far superior to attempts at skin grafting. It is frequently advisable to remove the proximal third of the nail in compound injuries involving this region. This procedure allows free drainage of infection about the eponychium, decompresses painful subungual hematomata, and may result in a smoother second-nail growth.

A special problem of the terminal phalanges is the so-called baseball fracture, or avulsion, of the extensor tendon with displacement of a chip from the articular surface of the terminal phalanx. Usually the extensor tendon does not retract and immediate fixation in plaster, maintaining the distal joint in hyperextension and the proximal interphalangeal joint in flexion for six weeks, is the treatment of choice. The results of those injuries which include a chip fracture are, as a rule, much better than those consisting of tendon avulsion only. The results from open reduction are less favorable than those with closed treatment, instituted early.

FRACTURES OF THE MIDDLE AND PROXIMAL PHALANGES

The displacement of the fragments following fractures in these regions may require immobilization with the finger in either flexion or extension, as dictated by x-ray appearance. In general, fractures distal to the middle of the shafts of those bones will require fixation in flexion.

Skeletal traction is usually indicated in comminuted or compounded fractures of these bones, and should be applied in line with the desired position of the finger.

Compounded fractures of these regions present the poorest end results of this entire group of fractures, because of tendon adhesions and joint fixations. Immobilization time should be minimum, and active motion can usually be instituted within two to four weeks.

FRACTURES OF THE METACARPALS

The first metacarpal is frequently fractured near its base and may be of two general types. The transverse, impacted type, not involving the carpal-metacarpal joint, does not require traction, and simple correction of the adduction deformity by disimpaction and abduction is sufficient. Those fractures of the base of the first metacarpal, extending obliquely into the joint, are unstable, usually shortened and require skeletal traction for about four weeks.

Fractures of the metacarpal shafts usually result in dorsal angulation, because of the stronger pull of the flexor muscles, and should be maintained in well-moulded plaster, incorporating at least the neighboring fingers. The fingers themselves may be in partial flexion, but should be supported by the cast, which fits firmly beneath the metacarpal heads. These fractures are prone to be oblique and to shorten, and again skeletal traction should be applied and maintained to overcome all overriding.

Fractures at the neck of the metacarpal often present a difficult problem. Impaction should be broken up and padded pressure applied within the cast. Acute flexion of the finger, and upward pressure in line with the proximal phalanx, may obtain a reduction otherwise impossible to achieve. The metacarpo-phalangeal joint is especially vulnerable to puncture wounds, which require immediate and adequate debridement.

IN CONCLUSION

In general, emphasis should be placed upon the following:

(1) Early definitive care of fractures of the hand to a point that they are considered a surgical emergency.

(2) Accurate reduction, and traction when necessary.

(3) The use of nonpadded, well-moulded plaster casts which obtain maximum immobilization of the fragments, and yet allow maximum function and use of the noninjured portions of the extremity. Use of the uninvolved portions of the hand during immobilization should be encouraged, for it will greatly speed recovery and lessen disability resulting from fractures of the hand.

Permanente Foundation Hospital.

TREATMENT OF INDUSTRIAL EYE INJURIES*

JOHN N. OSBURN, M. D.
Los Angeles

THE prerequisites to good industrial ophthalmology are good light, good vision, and good instruments. Each emergency unit should have a separate cubicle for eye-cases. In this space there should be good light, a binocular loupe, a few drugs, including an anaesthetic, such as pontocaine or butyn, also mercurochrome (one per cent) and a solution of boric acid; a sharp-pointed and a dull spud, and alcohol (seventy per cent) for sterilizing instruments. I feel that argyrol should not be on this list, as it is too often confused with tincture of iodine. Yellow oxide of mercury is irritating. The use of mydriatics, except in extreme cases, should be left to the judgment of the ophthalmologist.

Foreign bodies of the cornea should be treated with great respect. Those in the center should be referred to an ophthalmologist, as bad results are costly in man-hours, and large permanent disability ratings. Those at the limbus do not justify such great care. Give the anaesthetic time to work, and the patient will be more coöperative. If the foreign body is superficial, attempt to remove it with a tightly-wrapped, moist cotton applicator. If unsuccessful, use your spud, follow with a drop of mercurochrome, which not only stains and may show other wounds or foreign bodies, but also acts as a germicide. Inspect the everted lid of the injured eye, and also examine the opposite eye. Apply a pad for an hour or two, as, according to Behrens, the lachrymal secretion is an effective germicide. Instruct the patient to return the same day, if irritation continues, and also to return the next day for observation and a rating of vision if the eye is in good condition.

Every red eye seen is not necessarily an injured eye or a conjunctivitis. Conjunctivitis usually shows redness, swelling, and discharge. Iritis and glaucoma also cause redness in the eye, but no discharge. These two conditions are too often treated as a simple conjunctivitis, until visual damage has been done. Severe pain indicates a deeper inflammation; wherefore, if not sure of your diagnosis, refer the case to an ophthalmologist. A conjunctivitis usually responds rapidly to treatment.

Kerato-conjunctivitis is difficult to diagnose in the early stages. The patient usually has a tearing, red eye, with the sensation of a foreign body or an arc burn. Eventually, follicles appear in the lower cul-de-sac. There may be a slight rise in temperature; later on, swelling and tenderness of the preauricular glands on the affected side.

Flash burns always involve both eyes, and usually the symptoms do not appear for several hours after exposure, with photophobia, tearing and sensation of sand in the eyes. Treatment is a mild anesthetic, combined with adrenalin or other vasoconstrictor, cold compresses and protection from light. The discomfort lasts only a few hours.

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D

Chemical burns require copious flushing with water or boric acid. Always evert the upper lid, and remove any foreign particles and flush for twenty minutes.

These are the common cases which come to the emergency station. Any penetrating injury should immediately be referred to a specialist. Let me repeat: approach all injured eyes with clean hands, good light, and good vision.

523 West Sixth Street.

TREATMENT OF BURNS*

J. C. Rooney, M. D.
Santa Monica

THE fundamental principles in the management of burns are so well known that it is hardly necessary to repeat them:

1. Treatment of shock and relief of pain,
2. Prevention of infection and local treatment,
3. Attention to early functional return,
4. Correction of deformities or defects by skin graft, etc.

The treatment of shock involves relief from pain with copious doses of morphine. In a healthy adult male, as much as ½ gr. of morphine may be given at one time, and repeated whenever necessary.

REPLACEMENT OF LOST PLASMA

Plasma should be given in adequate amounts until the plasma balance has been reached. In a severe burn case, the author has given as much as 3000 cc. within eight hours. The most reliable method of calculating the amount of plasma required is that of Harkins:—100 cc. of plasma for every point above 45 in the hematocrit reading.

In the initial treatment of shock, the use of adrenal cortical extract has been reported favorably by some investigators and discounted by others. The action of the cortical extract is to restore the capillary walls to their normal state of permeability, and thus prevent protein loss. If epinephrine is used to any extent in cases of severe burns, frequent blood determinations of epinephrine should be made. In this connection, all cases of severe burns should have frequent plasma chloride determination and hematocrit readings, until the danger stage is passed.

Replenishing fluid loss can usually be accomplished by intravenous normal saline. It should be given in quantities sufficient to produce at least 1,000 cc. of urine daily. Fruit juices, to which glucose has been added, are important in combating hepatic damage.

It is imperative that the burned areas receive a meticulous and carefully-planned debridement and cleansing over the entire area. It is only thus that infections are prevented and convalescence is shortened. After the patient has been anesthetized with a general anesthetic or large doses of morphine, or a general anesthetic that is advisable in the circumstances, the cleansing is begun. Copious amounts of green soap are used in the first stage of the cleaning process. This is followed by irrigations (using sometimes gallons of sterile normal saline) to irrigate the burned fields.

DEBRIDEMENT

The debridement is the next important stage. This procedure is entitled to the same asceptic precautions as a surgical operation. The surgeon should scrub his hands and wear a mask, cap, gown and sterile gloves. All dead and unhealthy looking tissues are excised. Blebs should be left intact for two reasons: In the first place, they conserve the plasma which is in the bleb, and will be reabsorbed into the general circulation; and, in the second place, one less avenue of infection is kept closed.

To prove any one method to be superior to all others, stringent scientific checks and rechecks should be made with control series of large numbers of cases where burn cases can be classified in regard to (a) extent of burn, (b) depth of burn, (c) preliminary soiling, (d) length of time between burn and inauguration of treatment, (e) age, (f) structures involved.

On one occasion a patient presented himself with what appeared to be identically extensive burns on both hands, fingers and arms. For comparison, the left arm was sprayed with Pickrell's solution and a triple dye-method was used on the right arm. Daily salt water immersions, with active movement of the fingers, were begun on both hands after the fourth day. It was very noticeable that the hand, which was being sprayed with Pickrell's solution, responded far better. There was less pain on active motion, and the end result was superior to the hand which had received the triple dye treatment. In addition, two infected areas developed after the use of the triple dye with the formation of pus.

LOCAL APPLICATIONS

Since 1925, when tannic acid became the popular treatment for burns, literally dozens of medicaments in the forms of solutions, ointments and chemicals have been enthusiastically recommended.

Every chemical, agent, ointment or spray has its champion. The author has used Pickrell's 3 per cent sulfadiazine spray on many occasions with very satisfactory results.

True bactericidal action is exercised from the outset. The sulfadiazine spray contains a wetting agent. The author uses no dressings on burned areas. The burned areas are sprayed daily with Pickrell's solution, and although there is preliminary discomfort, the patient feels much relieved fifteen or twenty minutes after the spraying has been applied. Recently the use of pressure-dressing has become popular, with splinting in cases where the extremities have been badly burned. It is said that lymphatic circulation of the part is restricted, and there is marked decrease in exudation from the surface. Practically no infections have followed this procedure. This is a valuable adjunct to treatment when skin graft is contemplated, since the poor results of skin grafting are usually attributable to low-grade infections in the eschar and granulation areas. In this connection it is advisable that no skin grafting be accomplished until sterile cultures from the burned areas have been obtained.

The transparent jacket system recently advanced by Beverly Douglas has many advantages, especially when proper hospital facilities are available, and it appears to be a valuable addition in the treatment of burns. This jacket is a transparent, cylindrical tubing of cellulose acetate with one end closed by a flat, or rounded head of the same material. This type of jacket may be hermetically sealed at a point above the burned area. The atmosphere surrounding the wound may be regulated at will in these jackets. The hermetically-sealed closure and covering provide many useful purposes. The patient may turn in bed, thus preventing development of contractures, decubitus ulcers and outside sources of contamination. The jackets may be completely filled with normal saline or other solution, and a constant flow established by the drip method. The advantages of visibility is not minimal, since early evidence of pressure sores, decubitus ulcers, etc., can be detected.

* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

CONCLUSIONS

1. The primary consideration of shock should never be overlooked. It is vitally important to adopt and learn a simple method for determining the amount of plasma, versus cells, and administer plasma accordingly. The Harkins method is recommended.

2. The preparation of the burned patient is an asceptic surgical procedure.

3. Pickrell's solution of sulfadiazine spray is the procedure of choice, with daily normal saline hydrotherapy as an adjunct.

Pressure bandages and transparent jacket system are discussed.

3000 Ocean Park Boulevard.

CONTROL OF TOXIC EXPOSURES*

(Concluded from Page 13)

per cent of the velocity within the duct. Therefore, it is essential that any exhaust system must be applied at the point of origin of the material over which control is desired; i.e., it must be truly *local* exhaust ventilation.

(Special Note: the above-mentioned are *general* control principles, and it must be stated that there are certain measures which may be employed in special instances, such as wetting to minimize a dust problem.)

When all of these methods of control must be ruled out because of some production snag or lack of materials, or because the expense is not justified, e.g., short-time exposure to relatively low concentrations, the last resort is . . .

5. *Personal Protective Equipment.* There are many types of personal protective equipment for protection against mechanical injury as well as occupational diseases. Inasmuch as occupational diseases most frequently arise from the inhalation of toxic agents, said personal protective equipment is usually in the form of some type of respirator. In general, respirators are uncomfortable to wear, and their sanitation is not always what it should be. Consequently, the workers will frequently not wear the respirators. Hence, control of the environmental air is much more effective than the uncertain use of individual respirators.

However, there are times when the only alternative is the use of respirators. Each type of respirator is designed for a specific hazard. Not infrequently, however, we have noticed that a simple *dust* respirator is employed for the desired purpose of controlling an *organic vapor hazard.* Table 1 is a ready-reference chart listing the basic exposures with appropriate respirators indicated, as well as the limitations thereof.

808 North Spring Street.

Diphtheria in California

(COPY)

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH
BUREAU OF EPIDEMIOLOGY

Diphtheria Cases Reported by Months for Year 1944

January	127
February	118
March	119
April	94
May	103
June	90
July	59
August	83
September	67
October	93
November (reports received through Dec. 5)	148
Total	1101

(COPY)

California State Department of Public Health
Notice to Health Officers

December 4, 1944.

Attached is a copy of a letter sent to all physicians in Berkeley and Oakland by their respective health officers, calling attention to the presence of the *Gravis* type of diphtheria.

This type of diphtheria calls for prompt administration of antitoxin in maximum dosage. Because speed is essential in treating this type of diphtheria it is recommended that physicians treat all suspected cases of diphtheria with antitoxin at once without waiting for laboratory confirmation.

Your attention is called to the fact that the Gravis type cultures may not develop characteristic morphology with 24 hour incubation, but that it may be necessary to incubate cultures for 48 hours or longer before the organisms may be identified.

In serious cases of diphtheria from which only negative cultures are obtained it is recommended that subcultures be sent to the State Laboratory for further study.

Bureau of Epidemiology, 1122 Phelan Bldg.,
San Francisco, 2.

* * *

CITY OF OAKLAND
Department of Public Health
CITY OF BERKELEY
Department of Public Health

Dear Doctor:

During the past three weeks we have had in the East Bay Area a sudden increase in diphtheria. To date we have had 13 cases and 3 deaths.

The fact that makes this especially important is that the B. diphtheria is of the *Gravis* type. This is the most toxic type, originally reported in England, and reported throughout the United States increasingly during the past ten years.

Myocardial damage is extremely common in this type of infection, death taking place from seven to ten days after the onset of the disease and following clearing of the throat infection.

Throat cultures from suspected cases cannot be considered negative unless no organisms are seen following 48 hours incubation.

Immediate treatment is recommended on all suspicious cases (sore throat with suggestive membrane and low temperatures) regardless of culture findings.

Diphtheria antitoxin given—10,000 units intra venously and 30,000 units intra muscularly as soon as a provisional diagnosis is made, is recommended.

Additional antitoxin may be advisable during the first 24 hours if the case shows any degree of toxicity.

Prolonged bed rest in all cases is advisable.

Booster doses of toxoid are recommended for all children whose primary immunization was 2 years or more ago.

Sincerely,
(Signed) S. F. FARNSWORTH,
S. F. Farnsworth, M.D.,
Health Officer, Oakland.
(Signed) FRANK L. KELLY,
Frank L. Kelly, M.D.,
Health Officer, Berkeley.

Basil Valentine, possibly the pseudonym of Johann Thölde, an alchemist of Franckenhausen, was the author of "The Triumphal Chariot of Antimony," printed in 1604, in which a mixture of mercury, lead and antimony is recommended in the treatment of syphilis.

* Conclusion of article by Hugh Dierker, M.D. and Paul G. Brown.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

SPECIAL MEETING: C.M.A. HOUSE OF DELEGATES

Important. Attention of C.M.A. Members Is Called to: Proposed Compulsory Health Insurance Law for California

Note. In the current issue, on page 1, editorial comment is made concerning the sequence of events that led up to the Special Session of the House of Delegates of the California Medical Association and the proceedings that have followed.

The series of minutes, resolutions and press notices which follow, appear in this department, because the importance of the issues involved, make it desirable that proper record be kept in the OFFICIAL JOURNAL *of the California Medical Association.*

The resolutions adopted by the C.M.A. House of Delegates, representing the decisions of that authority, appear in the current number, on page 32.

(For index of items which follow, see page 40.)

* * *

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Eighty-sixth (186th) Meeting of the Executive Committee of the California Medical Association

An informal meeting (minutes as here given were approved by mail vote) of members of the C.M.A. Executive Committee, and members of the C.M.A. Council and other Officers of the Association was held in San Francisco on Tuesday, December 12, 1944, at the hour of 7:00 P.M.

1. **Roll Call:**

Executive Committee Members Present: John W. Cline, Chairman; Lowell S. Goin, Karl L. Schaupp, and George H. Kress, (ex-officio).

Absent: Philip K. Gilman (illness); E. Vincent Askey (transportation).

Council Members Present: Sidney J. Shipman, Edwin L. Bruck, Lloyd E. Kindall, John W. Green, Donald Cass, L. A. Alesen, R. Stanley Kneeshaw, Frank A. MacDonald, Sam J. McClendon.

Present by Invitation: Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; J. B. Harris, Hartley F. Peart, Esq., Legal Counsel; Howard Hassard, Esq., Associate Legal Counsel; Mr. John Hunton, Executive Secretary; and Mr. Ben Read, Secretary, Public Health League of California.

Letters were received from the following Councilors who regretted their inability to be present: Philip K. Gilman, Council Chairman; H. A. Johnston, Edward B. Dewey, Dewey R. Powell, Earl R. Moody, A. E. Anderson, E. Vincent Askey, Harry E. Henderson.

2. **Prospective Compulsory Health Legislation:**

The meeting was called to order by Executive Committee Chairman John W. Cline, who said he would call upon members to informally discuss problems of medical care of groups of low-income citizens of California. Dr. Cline stated that imminent legislation for compulsory

sickness insurance had been called to the attention of Council Chairman Gilman.

A general discussion followed concerning the information to the effect that one or more of the major Labor organizations would submit to the California Legislature, when it convened on Monday, January 8, 1945, drafts of one or more bills containing provisions for a compulsory sickness insurance system, to be conducted under the supervision of the State of California.

The discussion was participated in by many of the C.M.A. Councilors who were present.

Mention was made that Council Chairman Gilman had called an informal meeting of members of the Council of the California Medical Association, to be held on Wednesday noon, December 13th, at which Governor Earl Warren of California had been invited to address the group.

In the further discussion, comment was made concerning possible details of compulsory sickness insurance plans.

The meeting being of an informal nature, no action was taken other than to agree that all present should make a special effort to be present at the meeting on the following day at which the Governor of California would be the Guest Speaker.

JOHN W. CLINE, M.D., *Chairman.*
GEORGE H. KRESS, M.D., *Secretary.*

* * *

(COPY)

State of California
Governor's Office
Sacramento 14, December 22, 1944

George H. Kress, M.D.,
Secretary-Editor,
California Medical Association,
450 Sutter Street,
San Francisco 8, California.
Dear Dr. Kress:

Governor Warren has received your letter of December 18th enclosing copy of letter written by Dr. Harris of Sacramento, and copy of the Official Call for a special session of your House of Delegates.

He has asked me to state to you that he appreciates the thoughtful manner in which your Association is approaching this problem, and will be interested to follow the result of your deliberations.

Sincerely,
(Signed) BEACH VASEY, *Legislative Secretary.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-First (321st) Meeting of the Council of the California Medical Association

An informal meeting (minutes as here given later approved by mail vote) of members of the Council of the California Medical Association, to which had been invited members of the Board of Trustees of California Physicians' Service, and others, was held in San Francisco, at the Family Club, on Wednesday, December 13, 1944, at the noon hour.

1. Roll Call:

The meeting was attended by the following:

Councilors present: Philip K. Gilman, Council Chairman; John W. Cline, Vice-Chairman; Edwin L. Bruck, John W. Green, Donald Cass, Lloyd E. Kindall, R. S. Kneeshaw, Karl L. Schaupp, Lowell S. Goin, Sam J. McClendon, Sidney J. Shipman, and George H. Kress, Secretary.

Present by Invitation: The Honorable Earl Warren, Governor of California; Ray Lyman Wilbur, T. Henshaw Kelly, H. R. Madeley, C. Glenn Curtis, Chester L. Cooley, members of Board of Trustees of California Physicians' Service; Dwight H. Murray, Chairman C.M.A. Committee on Public Policy and Legislation; Wilton L. Halverson, Director of Public Health, State of California; J. B. Harris of Sacramento; H. Gordon MacLean of Oakland, Hospital Service of California; Ernest Sloman, D.D.S., Dean College of Physicians and Surgeons (Dental), San Francisco; Hartley F. Peart, Esq., C.M.A. Legal Counsel; Howard Hassard, Esq., Associate C.M.A. Legal Counsel; John Hunton, C.M.A. Executive Secretary, Ben Read, Secretary, Public Health League of California; Messrs. Sweigart and Vasey, Secretaries to Governor Warren.

Councilors and C.P.S. Trustees who wrote it would be impossible to be present included: Councilors A. E. Anderson, H. A. Johnston, Dewey R. Powell, Edward B. Dewey, E. Earl Moody, Frank A. MacDonald, and H. E. Henderson; C.P.S. Trustees C. L. Mulfinger, Rt. Rev. Thomas J. O'Dwyer, Glenn Myers, and A. E. Moore.

2. Purpose of Meeting:

Council Chairman Gilman opened the meeting by calling attention to trends of thought and action on the part of large groups of citizens not only in California, but throughout the United States, regarding plans to bring about a betterment in distribution and availability of adequate medical care, with special relation to the needs of citizens belonging to the lower income groups.

Council Chairman Gilman stated information had been received that at the next session of the California Legislature, which would convene on Monday, January 8, 1945, it was more than possible that one or more bills would be submitted by lay groups, providing for the institution of a compulsory sickness insurance system in California.

Because, in such proposed legislation, State and possibly Federal financial aid would be involved, it had been deemed desirable to invite the Governor of California to informally address the Officers of the California Medical Association on the above and related subjects.

3. Informal Address by Governor Earl Warren:

Governor Earl Warren then addressed the assembly.

In his presentation, Governor Warren stated that he had been happy to accept the invitation of the Officers of the California Medical Association to speak to them on the important subject of medical care, because his own observations had led him to believe that there was a distinct feeling on the part of a large number of voting citizens that ways and means should be provided, whereby adequate medical care would be made available to California citizens belonging to the low income groups. He was happy to outline his observations and view in informal manner to those present, because he felt medical care revolved in large measure around the functions of physicians, and the medical profession could be of great service in the proposed changes if its members offered constructive plans to the State's officials and the people of the State. At the close of his remarks, Governor Warren stated he would be happy to have questions put to him. A round-table conference followed. The importance of having the California Medical Association recognize existing and imminent conditions was emphasized by several speakers.

Subsequent to Governor Warren's departure, Vice-Council Chairman Cline took the chair and opened the meeting for further discussion, which followed.

4. Call for Special Session of C.M.A. House of Delegates:

Upon motion made and seconded, it was voted that a

call be issued for a special meeting of the House of Delegates of the California Medical Association, to be held in Los Angeles on January 4-5-6, 1945. A copy of the call for the special session is attached hereto. (Call was printed in the December issue of California and Western Medicine, opposite page 281.) The Call was submitted by mail vote to the Councilors and received the favorable vote of every Councilor.

5. **Invitation Extended to Governor Earl Warren to Address the House of Delegates:**

Upon motion made and seconded, it was voted that an invitation be extended to Governor Earl Warren to address the House of Delegates on January 4, 1945.

Much further discussion followed concerning sickness insurance legislation.

Adjournment followed at 5:00 P.M.

Philip K. Gilman, M.D., *Council Chairman,*
John W. Cline, M.D., *Council Vice-Chairman,*
George H. Kress, M.D., *Council Secretary.*

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Digest of Remarks by Governor Earl Warren at Meeting Held on December 13, 1944

(Memoranda re: Remarks by Governor Warren of California, at an informal luncheon conference held in Family Club in San Francisco on Wednesday, December 13, 1944, to which Governor Warren had been invited. Luncheon guests included members of Board of Councilors of California Medical Association, Board of Trustees of California Physicians' Service, and other C.M.A. officers and guests. Council Chairman Philip K. Gilman and Vice-Chairman John W. Cline, presided.)

* * *

In the course of his informal remarks Governor Earl Warren brought out the following thoughts:

Governor Warren expressed his appreciation at having the opportunity to talk to representatives of the medical profession, concerning medical care needs of citizens of California; and stated he felt that members of the medical profession, both as physicians and as citizens should have a special interest in medical care plans.

Concerning problems in medical care, Governor Warren said he did not have the answers. The responsibility of finding the answers devolved largely upon the medical profession. To date, the answers had not been given.

Concerning inadequacies in medical care, increasing blame was being placed upon the medical profession by many citizens. The subject had been under such wide discussion that today professional, social and political factors were all a part of the picture.

In any extension of medical care, through coöperation with governmental agencies, financial aid from both Federal and State agencies would come into play.

It was possible that some of the proponents of compulsory sickness plans would prefer to have State plans fail, to make easier the intervention of Federal agencies later.

For himself, Governor Warren felt that the protection and promotion of health among the citizens of California should be more a State rather than a Federal function.

Regarding the Wagner-Murray-Dingell bill as presented in the last U. S. Congress, he believed physicians, by and large, were not in favor of that measure. Nor was he.

It is important that some facts be recognized. Among such, was this,—the average American family of moderate income was not in position to purchase the medical care its members needed and wanted. This want, existing today, will continue to prevail in the future, unless Government steps in and helps spread the costs.

Governor Warren referred to the voluntary Statewide medical service sponsored by the California Medical Association, and operating as California Physicians' Service. He called attention, however, to the fact that at the end of some six years of existence, in California, a State with more than seven million population, the number of beneficiary members (patient members) in C.P.S. was only slightly above 100,000. This then, could not be looked upon as the answer to the people's health needs, even though it was a commendable and valuable beginning, and a possible nucleus for other endeavors.

Governor Warren referred to the C.M.A.'s November, 1943, survey of public relations made by Foote, Cone and Belding, and mentioned some of the interpretative figures that had been brought out by Mr. John Little.

Reference was also made to the sickness legislation proposed as long ago as 1915, when Senator Hiram Johnson was Governor of California. In this State, sickness and health plans had been the subject of much discussion since that time. The rest of the Union was watching California.

Governor Warren stated it was his opinion that the time had arrived when the parties immediately and more directly concerned would find it necessary to get together on a sickness insurance plan that would be acceptable to the people.

When World War II comes to a close, some eleven million men will return to their families. In California, perhaps 800,000 would come under Federal sickness plans, and, with their families, that number would be increased to two and one-half million citizens.

Governor Warren was under the impression, based on information that had come to him, that one or more compulsory sickness bills would be presented to the next California Legislature, which will hold its first meeting on Monday, January 8, 1945, at which time he would address the Legislature.

Governor Warren stated he had seen no drafts of bills, had not been in conference with any groups, but was glad to have the opportunity to express, to physicians, the hope that prior to the convening of the Legislature on January 8th next, information would be sent to him that the medical profession of California would present one or more constructive plans designed to give adequate medical care to California citizens.

Further, he stated he was of the opinion that, if throughout the United States, the various States took the leadership in constructive legislation, members of the Federal Congress would prefer to have sickness and health care be under State rather than Federal supervision.

He felt he should also inform his hearers, that if the next California Legislature failed to provide at least the fundamentals of a Statewide plan for medical care, other groups that were interested would carry the subject to the people, for initiative vote, with chances of favorable approval by the electorate.

Governor Warren closed his remarks by stating that he hoped the medical profession of California would sense its responsibility in these matters, and take the initiative both in the Legislature and in any appeal to the electorate.

Also, he would remain to hear opinions of those present, and try to answer questions put to him.

* * *

Open discussion followed, in which many Councilors and others participated. Among items touched upon were the following:

(a) Voluntary sickness plan is not the answer to the people's health and sickness needs.

(b) It was desirable that the physician-patient relationship be maintained.

(c) A California State agency, through which funds could be collected and disbursed, might be the California Unemployment Commission.

(d) Not desirable to have doctors giving service on payroll basis.

(e) Contracts might be made with nonprofit medical care organizations. C.P.S. an example. However, no monopoly set-up would be permissible.

(f) Would include certain now exempt groups in plan, namely, household employees, agricultural workers and others.

(g) Was in favor of proper compensation to physicians who cared for indigent citizens. Plan should make provision for this.

(h) All licensed physicians and surgeons (M.D.'s and Osteopathic P. and S.) should have equal rights.

Concerning other groups, with different standards, was not prepared to give an answer.

(i) State, County, City and Local governmental agencies must be responsive to Federal suggestions (when Federal aid is given) but not be under Federal control.

(j) Hospitalization provisions, dentistry and other accessory aids, must all be recognized in a large plan.

(k) People of the United States have long looked to California as being in the advance guard in social welfare agencies.

(l) In a governing board of a Statewide plan, say of seven members, four members thereof could be of healing art professions.

(m) Ceiling income level of citizens to be covered, to be a subject of actuarial and other study.

(n) Conceded that medical profession does not want to be regimented.

(o) Medical profession should be the plaintiff by submitting to the Legislature a program for adequate medical care. Should not permit itself to be placed in rôle of defendant.

(p) If medical profession presented no constructive plan, and Legislature passed a bill sponsored by others, then if such measure not vicious, might be obliged to let same become a law.

(Signed) George H. Kress, *Secretary.*

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(copy)

State of California
Governor's Office
Sacramento 14, December 28, 1944.

George H. Kress, M.D.,
Secretary-Editor,
California Medical Association,
San Francisco 8, California.

Dear Doctor Kress:

Governor Warren has received your letters of December 27th enclosing you memoranda concerning his informal remarks at the December 13th luncheon in San Francisco, and a rough draft of the minutes of a Council meeting of your Association.

He has asked me to tell you that he sees no reason why these do not correctly state the substance of his remarks, and correctly state the fact of his presence for the minutes.

He wishes me to express his appreciation for your courtesy in submitting these to him for his inspection.

Sincerely,

(Signed) Beach Vasey, *Legislative Secretary.*

* * *

Call For Special Session
House of Delegates of the California Medical Association
Notice of Special Meeting

To the Members of the House of Delegates of the California Medical Association:

The Council of the California Medical Association at a special meeting thereof, duly held on Wednesday, the thirteenth day of December, 1944, at San Francisco, California, by the affirmative vote of all members present, as confirmed by official mail vote, constituting more than two-thirds of all of the members of the Council, adopted the following resolution calling a special meeting of the House of Delegates:

Resolved, That a special meeting and session of the House of Delegates of this Association, California Medical Association, is hereby called to be held at the Elks Temple, at 607 South Park View (corner West 6th Street and Park View, in the City of Los Angeles, State of California, on the fourth, fifth and sixth days of January, 1945, (Thursday, Friday, Saturday), at the hour of 11 o'clock a.m. for the purpose of:

(a) Considering and acting upon legislative proposals relating to state medicine likely to be introduced by certain groups in the coming session of the California Legislature; and

(b) Formulating and acting upon one or more statewide health service legislative proposals satisfactory to a majority of the membership of the C.M.A. House of Delegates; and

(c) Considering and determining the general policies of the California Medical Association at the forthcoming session of the Legislature with reference to legislation or public policy affecting or concerning medical practice in all its phases, payment for the cost of medical care, and all related matters.

Further Resolved, That George H. Kress, the Secretary of this Association, be and he is hereby directed to prepare a written notice setting forth the time and place of meeting and the purposes and objects thereof and transmit the same, signed by him and attested by the President, the Chairman of the Council, and the Speaker of the House of Delegates in the manner and within the time required by the Constitution of the Association.

Secretary's Notice.—Pursuant to said resolution of the Council, you and each of you will hereby please take notice that a special meeting of the House of Delegates of the California Medical Association will be held at the Elks Temple, at 607 South Park View (Corner West 6th Street and Park View), in the City of Los Angeles, State of California, on the fourth, fifth, and sixth days of January, 1945, (Thursday, Friday, Saturday), at the hour of 11 o'clock a.m. of said days, and that the objects and purposes of said special meeting are those objects and purposes set forth in the resolution of the Council, above quoted.

The delegates and alternates who shall be eligible to be seated in the House at said special session shall be those delegates and alternates who were eligible to serve on the seventh day of May, 1944. (At the California Medical Association annual session at Los Angeles.)

(Signed) George H. Kress,
Secretary of the California Medical Association.

Attest to Official Call:

Lowell S. Goin,
President of the California Medical Association.

E. Vincent Askey,
Speaker of the House of Delegates of the California Medical Association.

Philip K. Gilman,
Chairman of the Council of the California Medical Association.

San Francisco, December 13, 1944.

Warren Will Seek State Health Bill

Governor Favors Compulsory Plan of Employer-Employee Contributions

Sacramento, December 29.—Governor Warren today announced he will sponsor a measure at the coming session of the Legislature providing "prepaid medical care through a system of compulsory health insurance" for California citizens.

Enactment of this program would put California in the forefront among the States; none has such a plan.

The program would be financed by contributions by both employers and employees. A program of protection, likewise, would be arranged whereby self-employed and all other qualified residents of the State could, by making contributions, come under the program.

Conferences already have been held by the Governor with the council of the California Medical Association and the House of Delegates of that organization will act on the Governor's plan at a Los Angeles meeting January 4-6.

"I am not for State medicine," said the Governor, in making clear the difference between his proposal and any scheme to put the doctors on a State pay roll and "pay for the medical and hospital expenses of the people out of public funds."

Levy of 1½ Per Cent

"My information," he said, "is that we can do the job by a 1½ per cent contribution each from employee and employer."

Present health insurance systems which met the standards set up in the proposed State compulsory health insurance plan would not be interfered with.

The Governor said it "may be necessary for the State to stabilize the health insurance fund during the first biennium," while a backlog of contributions builds up.

Warren said there appear to be "1,500,000 persons who are medically substandard in California." He said 38 of every 100 Californians called up by selective service had been rejected "because of physical or mental defects."

Warren said he had become convinced that "voluntary health insurance systems will not work because everybody will not join."—Earl C. Behrens, in Los Angeles *Times*, of December 29, 1944.

State Health Bill

Governor Proposes Compulsory Insurance Plan for California

Sacramento, Dec. 29.—(U.P.)—Governor Earl Warren today anounced he will submit to the California legislature meeting next month a plan of compulsory health insurance financed by a payroll tax on both employers and employees.

The Governor said the insurance plan would cover both contributors and their families and would provide for payment of costs of medical and hospital care. He said he believed the expenses for purchases of drugs and perhaps for basic dental care also should be included.

The plan probably can be financed by a 1½ per cent payroll tax on both employees and employers, Warren said, although he emphasized that the rate cannot yet be estimated exactly.

"I am not for State medicine," Warren said, "where doctors are put on the public payrolls and care is paid for from governmental funds. I don't believe in that system. . . . I do want to spread the cost of medical care by compulsory contribution of workers and industry, both of whom would be beneficiaries."

He pointed out that there have been attempts to set up health insurance plans in California for 30 years, culminating in the establishment of the California Physicians' Service in 1938, but that they had not been completely successful because they do not cover enough persons.

(A Statewide prepaid medical insurance plan for all workers covered by unemployment insurance is a major part of the California CIO legislative program, CIO Secretary Mervyn Rathborne said when asked to comment on the Governor's proposal. The CIO, Rathborne said, has prepared legislation along the lines recommended by Governor Warren for submission to the coming legislature. The State CIO executive board will meet January 11 to 14 in Oakland to put the finishing touches on their complete legislative program.)—Editor People's World.—California *People's World*, December 30, 1944.

Governor Warren to Ask Compulsory Health Insurance for State

Sacramento, Dec. 29—(U.P.)—Governor Earl Warren today announced he will submit to the California Legislature meeting next month a plan of compulsory health insurance financed by a pay roll tax on both employers and employees.

The Governor said the insurance plan would cover both contributors and their families and would provide for payment of costs of medical and hospital care. He said he believed that expenses for purchases of drugs and perhaps for basic dental care also should be included.

The plan probably can be financed by a 1½ per cent pay roll tax on both employees and employers. Warren said, although he emphasized that now the rate cannot be estimated exactly.

Not State Medicine

"I am not for State medicine," Warren said, "where doctors are put on the public pay rolls and care is paid for from governmental funds. I don't believe in that system . . . I do want to spread the cost of medical care by compulsory contribution of workers and industry, both of whom would be beneficiaries."

He pointed out that there have been attempts to set up health insurance plans in California for 30 years, culminating in the establishment of the California Physicians' Service in 1938, but that they had not been completely successful because they do not cover enough persons.

Pay Roll Tax

The pay roll tax, the Governor said, probably would be collected by the State Department of Employment, while the Department of Public Health would administer details of the plan with advice of a council representing employers, employees and physicians.

He emphasized that the plan would require setting of a scale of fees for different types of medical services. However, he declared it would "not change the relationship of doctor and patient and would provide for freedom of choice of physicians," he said.

"I'm convinced," Warren said, "that the time has arrived when we must in order to fill our obligations have such a system. We have talked about the matter in California for years. . . . But, we never have gone very far beyond the study and talk stage although we have known that adequate medical care and hospital service is beyond the reach of the average citizen.

Figures Cited

"Everybody has said for years that service is available only to the wealthy and the indigent, and there is considerable truth in the statement."

Citing figures of the State Selective Service System as showing a need for an improved health program, Warren said that of every 100 California men examined for induction into the armed services 38 have been

rejected on account of physical or mental deficiencies.

In all, he said that 374,000 men between the ages of 18 and 36 have been found defective. If the figure were projected, he said, it means that about 1,500,000 California residents are below standard in health.

Startling to Some

"I'm sure that there are many people who will be startled at the idea of compulsory health insurance," Warren siad. "But there are always people startled at new things even when they have to be done."

The Governor said that it might be necessary for contributions to start some time before benefits can be inaugurated, or the State might guarantee the benefit fund during a trial period.

The coverage should be broader than present coverage of unemployment insurance, taking in self-employed and other groups, Warren said. He added that it might be wise, at least at first, to place a ceiling on the income level of persons covered in the plan.

Physicians, he said, could elect to give service under the plan and conform to a rate schedule or not, as they pleased.—Stockton *Record,* December 29.

Warren Urges Compulsory Health Plan

Sacramento, Dec. 29.—(I.N.S.)—A system of prepaid medical care through compulsory health insurance for Californians was recommended today by Governor Earl Warren.

The proposed health insurance would cover families of workers contributing to the fund as well as those paying the insurance, and, in addition, would take in groups not now covered by unemployment insurance, such as the self employed.

The Governor made his disclosure at a third in a series of news conferences designed to give a "preview" of the legislative program to be recommended to the 1945 session.

Governor Warren declared he was convinced the time has arrived when California must inaugurate such a system to raise the State's standard of health.

Contributions Plan

Warren said that he believed a "reasonably sound" program could be financed through compulsory contributions from wage earners and employers of 1½ per cent each.

In setting up such a system, the Governor added, he did not want to see State medicine, which he described as a system under which doctors are placed on the public payroll and medical care paid for out of public funds.

"I don't want to change the professional relationship of the doctor and patient," Warren explained. "I want freedom of choice to exist for both. But we do want to spread the cost of medical care by compulsory contributions of workers and industry, both of whom will be the direct beneficiaries of such assistance."

In citing the need for compulsory health insurance, the Governor estimated at least 1,500,000 Californians were in sub-standard health.

He based his estimate on recent reports of Selective Service headquarters, which showed that to date more than 374,000 youths between 18 and 36 have been rejected by the armed forces because of mental and physical deficiencies.

These figures of the draft rejections, Warren declared, present "an amazing and shocking story."

"I am sure," said the Governor, "that there will be a lot of people startled by the thought of compulsory health insurance, but I think we are always startled by doing new things even though we have known they were necessary."

Warren said there was a great need for such a system and in his opinion, "fear should not deter us from trying to inaugurate it."

Although admitting details of the proposal have not been worked out—and that these details generally would be worked out by the legislature—the Governor said it was probable most of the contributions would be collected through the State unemployment insurance system.

He said that probably the State Department of Public Health should administer the program through a separate division, with a State council on health insurance setting general policies.

This council should be made up, Warren said, of representatives of interested groups, such as workers, employers and the medical and dental professions. He added that the proposed health insurance program probably could well include basic dental care but just how extensive would be a problem to be worked out later.

Under the system, doctors would work on a fixed fee basis, with the patient free to choose his own doctor and hospital.

Declaring Governor Earl Warren's proposal for compulsory health insurance is "a matter of grave importance to the entire future of the medical profession," Dr. John W. Cline, chairman of the executive council of the California Medical Association, disclosed today a special meeting of the Association's House of Delegates has been called.

The meeting, covering January 4, 5 and 6, will be devoted to "discussing the Governor's and various other health plans, and it is possible that a specific plan will emerge from it," Dr. Cline said.

"It was our understanding," he said, "that the Governor wished the medical profession to promulgate a plan, and it is for that purpose, and for the purpose of discussing the entire field of medical insurance and possibly promulgating a plan, that the House of Delegates has been called into session.

"Approximately 150 delegates from the entire State will attend."—Robert C. Weakley, Staff Correspondent International News, in San Francisco *Call-Bulletin,* December 29, 1944.

Compulsory Health Service

Governor Warren strikes out boldly into a progressive but highly controversial field with his announced intention of submitting a compulsory health insurance plan to the forthcoming session of the Legislature.

No doubt he was encouraged to take the step by the growing favor of the medical profession for a modified brand of State medicine, following experience with the California Physicians' Service, a voluntary plan operated by the doctors themselves. In some respects this plan has worked well, but it has failed to attract a large enough representation of low-paid workers among its beneficiaries to be worthwhile as a broad social agency.

But also, the Governor's move doubtless was stimulated by knowledge that the CIO is determined to put through legislation for a Statewide system either by the 1945 Legislature or by popular vote at the next general election. The doctors, too, were quickened to action by fear that labor would achieve something more akin to actual State medicine than they desire.

Regardless, however, of the incentive or source, the proposal will meet with enthusiastic support in many quarters. Not until the plan actually is drafted and the details known can it be appraised, but the principle will be subscribed to by thousands of citizens who long have felt inequalities of the cost of medical care.

* * *

In effect it is a compulsory saving arrangement where-

by employer and employee will join in establishing a fund under State management from which medical expenses may be provided for wrokers and their families within a certain income group. Presumably it will cover about the same number as the present unemployment insurance, although the Governor suggests a larger coverage may be found desirable. Broadly the set-up and procedure will follow the unemployment compensation insurance practice, but with a liberalizing feature permitting beneficiaries to choose their own physicians, hospitals and other services. This avoids the medical profession's chief fear of State medicine—the creation of a body of State doctors on the public payroll. Physicians will be free to give service under the plan at established rates, or not, as they please.

Properly organized, with these provisions, the system should be no threat to the independence or earning ability of the medical profession. It would force workers to do what they ordinarily do not do—save money against the inevitable need for medical service. It would encourage them to seek medical service whereas now they avoid it on account of the expense. It would guarantee doctors full collection of their bills and probably yield them more income at lower rates per service rendered.

* * *

California has been a leader among the States in public welfare legislation. Its provisions for the aged, the blind, for indigent children, for tubercular sufferers, for injured industrial workers and for the unemployed have been more liberal than those of other States. Governor Warren is following the illustrious traditions of the State in proposing compulsory health insurance as the next step in California's enlightened social program.—Editorial in San Francisco *News*, December 30, 1944.

Governor Warren to Council Chairman Gilman

STATE OF CALIFORNIA
Governor's Office
Earl Warren, Governor

Sacramento (14), January 3, 1945.

Dr. Philip K. Gilman,
President-elect,
California Medical Association.

My dear Dr. Gilman:

The approaching session of the Legislature is so near at hand that it will be impossible for me to attend the meeting of the House of Delegates of the California Medical Association at Los Angeles, in accordance with the kind invitation of Dr. George Kress to address the gathering. I sincerely regret my inability to dicuss the all-important problem of health insurance with those who are guiding the destiny of your profession, because I believe the time for constructive action on this subject has arrived.

We have been talking about it for many years, the first Health Insurance Commission in California having been established by the Legislature exactly thirty years ago. Since that time interested groups, including your Association, have advanced proposals in the State Legislature, but none of them progressed beyond the talking stage. It is my opinion that through the passage of years and the development of a finer special conscience, most people are agreed that if we are to raise the health standards of our people to a plane consistent with our hopes for the future, we must have a system of health insurance that will spread the cost of medical care over the lifetime of those protected through regular contributions by themselves and the industry which they support. Recent surveys, including that conducted by your Association, have shown that the public is anxious and ready for action.

I believe that this realization has been crystallized by the startling and disappointing results of the Selective Service general physical examinations, which show that even in California, where we pride ourselves on our humanitarian institutions and our health standards, 38 out of every 100 boys examined were of necessity rejected because of physical or mental defects. Reduced to numbers, this means that 374,000 of what we generally consider to be the flower of the land, between the ages of 18 and 36, were rejected as unfit for service in the armed forces of our country. If we project this situation so as to include males who are in the younger and older groups, as well as to the other sex, the number of physically unfit becomes appalling. I believe most of us have hoped in years gone by that improved standards of living, new insurance practices, industrial health programs, etc., would permit us to have prepaid medical care on a voluntary basis. Many laudable programs have been initiated and chief among them is your own California Physicians' Service, but after more than six years of existence and with the blessing of your Association it has only enrolled something over 100,000 persons. To me and to many others, this means that such voluntary systems, desirable as they may be, cannot in and of themselves keep pace with public need and with the crying demands of our people. If this is true, it leaves but one alternative, and that is a system for prepaid medical care through Statewide health insurance.

In order to avoid misunderstanding, I would like to state what is not included, as well as what is included in this suggestion: First, I do not favor State medicine. By "State medicine," I mean the employment by the State of physicians to treat all persons, at public clinics or otherwise, at State expense. Second, I do not favor any plan which will destroy the professional relationship of physician and patient, or the right of choice of either in that relationship. Third, I do not favor political interference with the practice of medicine.

On the contrary, I want every person to have the right to select his own physician and every physician to have the right to treat whom he desires. I want medical practice to be left entirely uninhibited to pursue its present professional methods under a system whereby the cost of medical services for unemployed individuals and their families may be paid from a State fund to which they will contribute regularly. I am not committed to all the details of a plan, but I do want California to assume its full responsibility of maintaining proper health standards for all our people. I am hopeful that the details will be supplied by the interested groups, and particularly by your own which in my opinion rightfully is entitled to assume leadership in the solution of such an important problem of public health.

It was this belief that prompted me first to discuss the matter with you at Oak Knoll Hospital in November and then later with the Executive Committee of your Council at San Francisco. Needless to say, I was heartened by the fair reception which both you and your Council accorded the proposal.

The things that I believe should be incorporated in any such plan of health insurance are as follows:

1. A fund raised through payroll contributions payable in equal amounts by employers and by employees and collected wherever possible in the same manner as unemployment insurance contributions.

2. The administration of the fund to be by a medical director heading a division in the Department of Public Health.

3. The policies of the system to be formulated by a State board on which there should be representatives of

the medical and dental professions, of employers and employees.

4. The right of every person to choose his own physician or hospital, both of which are to be compensated on a fee basis as distinguished from a salary or capitation basis.

Here is an urgent need of the people of the State of California. No group is more vitally concerned than the medical profession. No group is more called on to find its solution. No group is better qualified to evolve a plan to meet the problem. I sincerely hope that as President-elect of your Association you will join with me in seeking the coöperation of the medical profession in working out the plan for which the people of our State are calling.

With best wishes, I am

Sincerely,

(Signed) EARL WARREN, *Governor.*

Health Insurance on Way, Union Leaders Tell Doctors

Regimentation Seen If Medical Men Don't Step In

Directing a message to the 10,000 licensed physicians in California, Eugene Boyd, an A.F.L. representative at a California Medical Association meeting here yesterday, advised them that if they wish to preserve "personal initiative" in medical practice they had better get out quick and fight for it.

"If the medical profession does not step in, it certainly will be regimented—make no mistake about that!" Boyd, a building trades union leader, told the doctors. He had been invited to address the meeting, specially called to consider current campaigns to set up State compulsory health insurance. He told the medical men that regardless of the name under which compulsory health insurance is put forth, "it is still socialized medicine."

Other Speakers

Boyd was the first speaker after Albee Slade and Mervyn Rathbone, State C.I.O. leaders, had explained the $250,000,000 compulsory health insurance plan which the C.I.O. hopes to have the coming Legislature set up.

A.F.L. Views

The A.F.L. man made it plain that A.F.L. leaders believe the time is here to provide far more medical care than generally is available, especially to persons of moderate or low income. He told of a vast but somewhat nebulous Federal plan for health insurance that is being promoted, said Gov. Warren has been studying this, and that the California A.F.L. is awaiting further moves in that direction by the Governor. He expressed the hope that the association will provide the leadership for what is to come along this line.

C.I.O. Ideas Outlined

Slade principally outlined the C.I.O. plan for compulsory health insurance. He said it is not socialized medicine and that the C.I.O. opposes socialized medicine. He offered it with a solicitation of help from the association, which had invited the C.I.O. to expound the plan to the doctors.

As understood by some of the doctors who have studied the C.I.O. plan, it would levy a new tax on a worker's income up to $5,000, another new one on an employer's pay roll and would draw on taxpayers in general for funds to finance the system. The public would pay the tax for the poor.

An extensive network of selected union men, employers and so-called "public representatives" and doctors would be set up to cover the State with administration machinery on a detailed scale.

"Free" medical care in homes and in hospitals would then be provided for eligibles. Doctors would receive their pay from the State.

Service for 6,000,000 California Citizens

Slade estimated that the "free" service would be extended to approximately 6,000,000 California residents to begin with and would provide "medical service on the basis of need instead of on ability to pay."

"Gov. Warren has found that health insurance is politically and socially the order of the day." Slade told the doctors.

Farm Bureaus

Von T. Ellsworth of the California Farm Bureau Federation, another invited speaker, told the doctors that "the time for action has arrived." He said he does not believe that voluntary health insurance has yet had a fair trial in this State. He spoke against compulsion and for extended medical facilities to persons not now procuring it, especially because of its high cost. Ellsworth believes some of the new social forces now at work are "going too fast." He wants further development of a voluntary plan.

State Board of Public Health

State Health Director Wilton Halverson referred to the Federal health care program promoted in Congress and warned:

"None of us believe that a medical program operated from the Federal level can ever give the best care. The leaders of the profession must do their best to develop a program to meet the social needs of the people but they must not be tied down with governmental red tape."

Throughout the day, various resolutions and proposals were discussed by the doctors, numbering some 200, and today they are to arrive at an association policy on the subject. Sessions are in the Elks Club.—Los Angeles *Times*, Saturday, January 6, 1945.

Resolutions Adopted by the C.M.A. House of Delegates on January 7, 1945, at the Special Session of the House of Delegates.

(COPY)

(Copy of the Foreword and Resolutions adopted by the House of Delegates of the California Medical Association, in special session in Los Angeles on January 4, 5, and 6, 1945.)

* * *

Los Angeles, January 7, 1945.

To the House of Delegates of the California Medical Association:

Your Resolutions Committee submitted a preliminary report at yesterday's meeting (January 5, 1945) and it will be assumed that the members of the House have in mind the general tenor of that report. At yesterday afternoon's session, twenty (20) resolutions were presented, in addition to those previously submitted, and all these your Committee had to consider between last evening's hour of adjournment and this morning's meeting, which was scheduled to begin at 9:00 A.M. Your Resolutions Committee remained in session until after one o'clock this morning, and it now submits to you this supplemental report.

Before proceeding with consideration of specific resolutions we believe it advisable, briefly to review the immediate circumstances leading up to this special meeting of the House of Delegates of the California Medical Association, so that the House may bear in mind one fundamental point, which is, that the House must give a specific answer to a specific question.

Early in December, 1944, His Excellency, Governor Earl Warren conferred with the officers and councilors of the California Medical Association and stated to them in substance that he favored and urged the establishment by law of a system for the distribution of the costs of medical care, to be financed, if necessary, through new and additional pay roll taxes. Governor Warren stated that he had an open mind as to the details of any such system. He requested the California Medical Association to inform him of the type of tax-financed medical care plan, if any, that the Association would approve.

Subsequently, officers and members of the Association have held informal conferences with representatives of organized labor and a representative of the California Farm Bureau. Representatives of labor and a representative of the Farm Bureau have appeared before the Council and before the delegates at this special meeting of the House of Delegates. The Governor of the State of California has asked of us a question. We must now proceed to answer it.

Most of the resolutions submitted by members of the House and considered by the Committee contain various answers to the Governor's inquiry. Your Committee felt that to consider each resolution separately would involve both duplication and unnecessary prolongation of this special three-day session. Therefore, your Committee has prepared a substitute resolution containing a specific answer to the question that has been propounded to the Association. The resolution proposes a plan for State assistance in the solution of the problem of the distribution of the costs of medical care, but it does not contain any acceptance, direct or indirect, of the basic provisions of any known compulsory health insurance system.

Your Committee recommends that this House of Delegates express its appreciation of the sincerity of purpose of the Governor, and the representatives of labor and of agriculture in their proposals looking toward a solution of the problems before us. We recognize with gratification that an important forward step has been taken in the furtherance of mutual understanding and coöperation between the California Medical Association and the leaders of the public its members serve. It is our earnest desire to seek the continued advice and coöperation of all parties having interests in the solution of our mutual problems.

Your Committee now submits the following resolution:

Resolved, That the California Medical Association is of the firm conviction that no fundamental and revolutionary change in the practice of medicine should be made under present wartime conditions. If disruption occurs in the rendering of medical service, the result can well be a catastrophe for the people of the State. That major disruption would occur if health insurance were made compulsory by the State is self-evident, regardless of approval or disapproval by the doctors of a new system in principle. This is true for two reasons: The doctors remaining in civilian practice, after over 3,000 or approximately one-third have gone into military service are barely able now to provide medical service for a greatly expanded population and greatly expanded industry and they do it by working to or beyond the limit of sustained endurance. If, now, they are forced to go through a period of change to a new and unfamiliar system of practice, medical service to the people will break down. This is not theory. We know from experience with California Physicians' Service that the process of educating doctors and patients, to say nothing of administrators, to operate under an unfamiliar system is not accomplished overnight.

Furthermore, from experience of California Physicians' Service, in the War Housing projects where a full coverage plan was in operation, it was found that the demand for service was vastly increased under a complete prepayment system—in fact as much as doubled. Without arguing how much increased service is or is not desirable, the plain fact is that the doctors are doing all they can now and a large increase in demand for service will with absolute certainty break down medical care in California; and be it further

Resolved, That the California Medical Association cannot endorse any system of compulsory health insurance which has thus far come to its attention; and be it further

Resolved, That the California Medical Association is equally convinced that there is an existing problem with respect to the distribution of the costs of health services and therefore, its position with respect to such problems must continue to be a positive and progressive one; and be it further

Resolved, That as such a positive and progressive step toward the ultimate solution of the problem, the House of Delegates of the California Medical Association hereby proposes the following program which it believes to be both desirable and feasible under all existing circumstances:

(a) An increase in the benefits of the California Unemployment Insurance Act, without increasing pay roll taxes, to provide cash indemnities to wage earners when ill or injured through non-industrial causes. Such cash indemnities would be primarily used for the payment in whole or in part of incurred hospitalization costs. This proposal is feasible because the present California Unemployment benefits and the estimated cost of adding cash indemnities can well be financed within the existing unemployment tax structure.

(b) The California Medical Association is wholeheartedly in favor of the principle of distribution of the costs of medical care by means of prepayment, and its sincerity in this regard is evidenced by its expenditure of no inconsiderable money and effort for the development of California Physicians' Service, and that California Physicians' Service has been offering to the public a statewide, nonprofit prepayment plan for the past five and a half years.

The California Medical Association respectfully insists that it is not an informed statement to characterize California Physicians' Service as a "failure because it covers only about 125,000 people." A brief review of its enrollment experience presents a fairer picture of its present status and future prospects. After its administrative organization was ready to operate in 1939, it took three weeks to enroll the first ten mmebers. Rate of enrollment in its first four years averaged about 1,000 per month. Now, with its more advanced "seasoning," with improvement in compensation to doctors, with better public knowledge of and confidence in it, rate of enrollment of new members has risen to approximately 12,000 per month in the last four months of 1944. If it is fair to judge the future by past experience, California Physicians' Service is, just at this time, entering upon a period of very rapidly increasing expansion.

The California Medical Association respectfully insists that instead of characterizing California Physicians' Service as a failure because it covers as yet an insufficient number of people, the State Government, Management, Labor and Agriculture should implement and assist California Physicians' Service to attain its objectives.

Such assistance could well be a reduction of the employees' portion of the California Unemployment tax for those employees who have joined California Physicians' Service or any other equivalent service. To illustrate this proposal—under it, an employee enrolling in California Physicians' Service (or in one of the Blue Cross Plans) would have a smaller sum deducted from

his pay check each month than he would if he failed to join. The amount of this reduction would be small, but its smallness is not important because the existence of any incentive will unquestionably act as a tremendous aid to the growth of voluntary non-profit plans. It may be claimed that this cannot be done without increasing existing taxes. Therefore, the following information is of importance. The present California Unemployment Tax consists of 3.7 per cent of all payrolls, 2.7 per cent paid by the employer, 1 per cent paid by the employee. This tax fund is collected under the present law for the sole purpose of paying cash benefits to people unemployed through loss of work. Since the inception of the California Unemployment system, the benefits paid out have been less than 1/3 of the amount of the taxes collected. Even in pre-war years the benefits paid out averaged not over half the taxes collected. Therefore it is apparent that a tax reduction to encourage medical coverage can be added to the Unemployment Act without jeopardizing the solvency of the fund and without adding to the tax burden. California is in an advantageous position in this regard because it is one of the few states that impose a 1 per cent unemployment tax on employees in addition to the 2.7 per cent employers' tax. It is this 1 per cent which has resulted in the California fund becoming extremely large and further results in the feasibility of our suggested plan. For instance, the present surplus is $621,708,167.89.

(c) A more rigid enforcement by the State of the various existing disease preventive measures and other public health laws should be undertaken. By this means, already at the command of the State, great strides can be made toward the reduction of the incidence of illness and disease. It must not be forgotten that all reductions in the incidence of illness decrease the cost of medical care. Better enforcement of existing preventive measures relating to tuberculosis, contagious diseases and, specifically, venereal diseases would reduce the incidence of these diseases and illustrate this point; and be it further

Resolved, That recent proposals to establish some form of compulsory health insurance in this State have come at the last minute without any opportunity for adequate consideration and planning by any of the many interested groups or sufficient time for interchange of opinions and knowledge. Very considerable progress has been made in defining objectives in recent meetings between representatives of the medical profession with the Governor and other groups, and it is the belief of your committee that such meetings and further exchange of ideas should be undertaken immediately, and continued until a definite conclusion has been reached.

I move the adoption of this resolution as a whole.

* * *

It is further suggested that the California Medical Association specifically and immediately invite representatives of the Government of the State of California, representatives of business and management interests, representatives of Labor, representatives of agricultural organizations, representatives of the dental profession, representatives of hospitals, and representatives of allied medical groups to joint conferences for the purpose of arriving at a complete and comprehensive plan to cover the entire problem of health service in California.

I move the adoption of this section of the Committees' report.

* * *

During the deliberations of the Committee, and from the study of the resolutions submitted, the Committee has formulated certain basic principles that are inherent in the success of every prepayment plan of health service. These principles are fundamental. They may be enumerated as follows:

1. Absolute freedom of choice of physicians by the patient must be guaranteed;

2. Payments for service rendered must be on the basis of fee for service as opposed to capitation, in payment of the physician.

3. Unhampered medical control of all professional service.

I move the adoption of this section of the committees' report.

Committee on Resolutions
by
Howard W. Bosworth, M.D., Los Angeles, Chairman.
Jay J. Crane, M.D., Los Angeles.
G. D. Delprat, M.D., San Francisco.
Walter Beckh, M.D., San Francisco.
Dwight H. Murray, M.D., Napa.

Health for All

Governor Earl Waren was tired of hearing Californians talk about the public health problem. He was tired of that old saying that "medical care and hospital services are available only to the wealthy or the indigent." He whipped up a plan which he announced last week he would present, with pressure, to the next Legislature.

The plan: All employed Californians (and eventually, their families) would be covered by compulsory health insurance which would be financed by docking 1½ per cent of their checks each pay day. Another 1½ per cent would be contributed by their employers.

Such little details as whether or not to fix price ceilings on medical services would have to be worked out by medical men and legislators, but the Governor was certain of one thing: His plan would leave patients free to choose their physicians and physicians free to practice where they please.

If the Governor's plan should be adopted—and health officials were speaking kindly of it last week—California would be the first State in the Union to make health insurance compulsory.—San Francisco *Chronicle*, January 7, 1945.

War Tosses Us a Challenge, Warren Tells Legislators

Sacramento, Jan. 8.—Here is the condensed text of Governor Warren's message to the 1945 Legislature:

I welcome you to Sacramento. In these trying times we can together do a better job for the people of our State than I can possibly do alone. . . .

We meet as representatives of a people who are conscious of the disruptions, the distortions, the congestions and the sorrows of three long years of war. They look to us for a steadying influence. . . . In the midst of these terrible strains, and they will of necessity increase, the people have the right to look to us for prompt decision in all matters concerned with the war effort.

They have the right to expect us to plan that our war-produced aggravations do not take permanent root. They expect us to start cutting away the handicaps to social and economic progress in the days of peace to come. . . .

There is much for us to do. There are many fields for us to plow together—fields that will produce rich crops of human betterment for our people—fields that are not in the zone of partisanship, but which are the common concern of all men. . . .

Government Is Sound

It is in this spirit, as well as in accordance with the Constitution, that I report on the condition of your State, the status of its Government and the needs of our people.

First, I report to you that your Government is sound

—sound in finances, in integrity and in conformation to the spirit and the policies established by your honorable body. . . .

Prepaid Medical Service

For many years California has been courageous in its undertakings in the field of humanitarian service to her citizens. Thirty years ago we started a movement for health insurance. It is now generally agreed that we cannot bring proper standards of health to the people of every community through voluntary programs. In spite of all our haphazard efforts, the only people who are certain of receiving adequate medical attention today are those who are wealthy, and those who are indigent and forced to accept charity. The great mass of our people are unable to pay for proper medical care when adversity strikes.

But it remained for the Selective Service to demonstrate the sordid results of neglected health. Even in California, 38 out of every 100 of our boys who were called to the service of their country were rejected because of physical and mental defects. In figures this adds up to 374,000. The total cost of the continuance of these defects and illnesses to our State is enormous. Everyone must be concerned. The fact is that most of these defects could have been prevented or cured by adequate and timely medical care.

It is my recommendation that you take action at this session of the Legislature on a program which will bring adequate medical care to the people of our State on a prepaid basis. It is my suggestion that this be accomplished by building a fund, through payroll deductions from both employer and employee, from which the costs of medical care can be financed. Such a program will pay dividends to everyone.

In our efforts to build an enlightened program, I believe we must make certain, both for the advancement of medical science and for the best interests of our citizenry, that the professional relationship of doctor and patient be a matter of free choice. We do not want to put the medical profession on the public payroll. We do not want to deprive the individual of the right to select his own physician. Our major purpose should be to spread the cost of medical care among all the people of the State.

There is no state in the Union better able to undertake such a humanitarian program than California. I am convinced that if we are to keep abreast of needs in the services which we afford our people, we must start on this program immediately. . . . San Francisco *News*, January 8, 1945.

Governor's Compulsory Health Insurance Bill

By Earl C. Behrens, Political Editor, The Chronicle

Sacramento, Jan. 10.—The Governor's bill for prepaid medical care under a compulsory health insurance system will be the No. 1 measure on the Warren program at this session.

A bitter controversy is brewing over the bill and efforts may be made to sidetrack it in legislative committees.

Warren told newsmen he and his staff worked late last night on the details of the measure. . . .

The Action Stage

The Governor will ask that there be no delays nor any more study committees on the health insurance program but that a bill be enacted at the 1945 session. He said today "we are in the action stage" and "we've been studying the subject for 30 years."

Warren said any further delays "would defeat the purpose of health insurance."

To date the Governor officially has received no help from the California Medical Association although individual leaders of that organization have discussed the program with the Governor.

"The bill will incorporate all elements of health insurance and I know of no reason why the Legislature cannot arrive at some judgment on it at this session," Warren said.

Worker's Indemnities

He said the suggestion from the House of Delegates of the State Medical Association that a system of worker's indemnities in case of illness be substituted for a complete health insurance program would not be sufficient.

Warren cited California's leadership in progressive legislation. "This program is in keeping with California's liberalism," he said.

The Governor said he was awaiting appointment of the members of the committees in the Senate and Assembly before making a choice of the members who will be asked to handle the health insurance legislation. The chairman of the committee handling public health may be asked to steer the Warren proposal. . . . —San Francisco *Chronicle*, January 11.

(COPY)

The Governor's Legislative Program

Information Bulletin: Merchants and Manufacturers Association for Better Employment Relations

January 10, 1945.

In his legislative program sent to the Legislature by Governor Warren were included the following, which directly or indirectly concern labor relations:

(1) A compulsory payroll tax on employers and employees of 1½ per cent, to be collected and disbursed by the State to provide medical and hospital service, apparently, according to the press reports, available for all our people. There will be a limitation upon the amount of individual pay to be so taxed, but that is not yet named.

Until the Governor's measure is actually introduced it cannot be properly appraised. But in the meantime, thought can be given to these inquiries.

(a) What factual demonstratoin has been made as to the benefits apt to be derived from this compulsory contribution? In a previous statement it was said that the draft showed a great many young men physically below par. That is true, but how many of these men would have been made physically fit by this proposed compulsory tax-pay medical system? How much of the unfitness was due to the people exercising their individual freedom, careless of their own physical welfare, and who would not seek or follow medical advice?

(b) Why should the employer be singled out to contribute to the welfare of the whole community without any definite assurance of benefit to him? Why should employees, as such, be taxed without their consent for the community benefit and without assurance as to any individual need, or individual willingness to make such contribution?

(c) No assurance is given that any such contributions can be deducted from the Federal income tax, the present provision of the law being that only amounts paid out for medical and hospital service in excess of 5 per cent can be so deducted. How much then will an employer, for example, who is now in the high-income brackets, have to pay out of what is left of his net profit?—especially if his payroll is half or more of his total operating expenses? How about the employee who earns say $2,500 per year and who will be obliged to contribute $37.50? What is his view as to the necessity for such contribution as against a possible benefit during that year?

(d) What will be the cost of administration by the State? What will be the procedure under which doctors and hospitals will get their pay? How and when? To what extent will their bills be subject to audit and other control by a State bureau?

(e) A very great many employers in this State already have long-established medical and hospital service with the coöperation of the employees, and developed through many years of experience. These voluntary associations are operating satisfactorily, and giving service to a very large number of people, running probably into the hundreds of thousands. What will be the effect upon them? The doctors have also established medical and hospital services on a voluntary insurance basis. Will these be disrupted? What will be the effect upon the *usefulness* of the physician? The hospital? Cannot these *voluntary* efforts be encouraged and increased?

(f) What safeguards are to be placed around this fund rising from compulsory taxation, with respect to its expenditure? Any limits on the individual demand? What will constitute eligibility for benefits? Is it to be upon a pay-as-you-go basis, or represent another "reserve" appropriation of taxpayers' money as against an undetermined need?

(g) It is hardly necessary to suggest in this connection that the present war measures of taxation cannot be permanenlty borne by our people. History has demonstrated that conclusion. They must be revised downward after the war. Is it wise then to add say $200,000,000 annually to that burden in this State at this time without knowledge of our postwar tax problems?—arising out of needs imperative in nature?

These are questions for you to consider and wherever practicable to ask your employees to consider. Then, the most important question of all—the very broad question of *how far* the State should go in making attempt to provide for the individual welfare of all its citizens through taxation either of certain classes, as in this instance, or of all. There are many ills that flesh is heir to; but can they be remedied by taxation? Where is State dependence to be substituted for individual self-dependence?

Then there is the final, as yet unanswerable, question—what will be the further call upon our incomes to win the World War? Whatever the merits of any new measures for using the taxpayers' money may be, is it not wise to defer them until we have victory and with it some measure of our postwar problems?

If these questions be bluntly put, it is with the hope that your thought individually may be aroused—and your conclusions aid in getting informed action.

(2) The other measures include extension of maximum unemployment insurance from 23 to 26 weeks, reduction of the waiting period before such payments begin from 2 weeks to 1 week, extension of the coverage of unemployment insurance to all employees, and other suggestions that do not directly relate to labor relations.

You will be promptly advised as to all proposed legislation affecting labor relations as fast as copies of such measures are available.

Medical Care

Whether Governor Warren's suggestion to the Legislature for a public medical care program opens the door to "State medicine" depends largely on the attitude of the medical profession.

Sooner or later there is going to be some sort of public program to provide medical care to the large majority of the population neither affluent enough to pay for the best nor indigent and so entitled to free care.

It can be guided by the medical profession so as to preserve the desirable relation of doctor and patient and protect the interests of both. If the medical profession shuns it, politicians will do the job and, as usually, with less satisfactory results. One of these will be "State medicine." Some other points in the Governor's suggestion, which he does not state arbitrarily, may be open to debate. The first and most important point is what the doctors will do about it.—Editorial in San Francisco *Chronicle,* January 10, 1945.

Health Insurance Bill Pressed By Warren

By R. W. Jimerson

Examiner Bureau, Sacramento, Jan. 10.—The assembly today voted unanimously to continue the $50 monthly old age pension on a permanent basis and at the same time moved to investigate pension advocates and promoters with particular emphasis on the collection of funds.

Meanwhile, Governor Earl Warren declared that passage of a compulsory health insurance bill is "one of the main orders of business" in his office, and that he knows of "no reason why the legislature cannot arrive at a sound decision this session." . . . Meanwhile, Governor Warren left no doubt that he will fight vigorously for enactment of a health insurance program, and similarly made it clear that he will urge adoption of a rounded plan, without compromising basic principles.

He said the compulsory health insurance bill is now being drafted in his office, that he and his secretaries worked on it until after midnight this morning, and that the mechanics of prepaid medical care are "very complicated."

Deduction Program

The Governor wants health insurance financed by pay roll deductions applicable to both employers and employees, with no strings attached. Every member of the family will be covered if the legislature takes the Warren program.

The house of delegates of the California Medical Association has declined to endorse the Governor's proposal. Many Republican legislators do not view compulsory health insurance with favor, either, but they are reluctant, at the same time, to oppose Warren, particularly as Democratic members are gleefully espousing the program. Also watching results is the CIO, which plans to present its own health program as an initiative measure at the 1946 general election, if Warren's bill fails to carry at this session.

Whatever the fate of his bill, Warren indicated he will not condone any stalling for time.

He said he could not tell who would handle the various administration bills until the committees are appointed, but added that he planned to confer with committee heads of each house as soon as appointments are made.—San Francisco *Examiner,* January 11.

Press Release from California Medical Association

San Francisco, January 11, 1945.—California's doctors are ready to give Governor Warren any requested assistance in writing his proposed health insurance bill despite the fact that the doctors have officially gone on record as being opposed to the compulsory system which the Governor has announced.

That statement was made here today by Dr. Philip K. Cilman, chairman of the Council and president-elect of the California Medical Association.

"The Governor has not requested the California Medical Association to give him any help on his proposed bill," Dr. Gilman said, "but the Association is ready and willing to supply any technical details which

the Governor may request. Through our experience of the past six years with California Physicians' Service we have accumulated a mass of actuarial data which we will be glad to lay in the proper hands upon request. It is doubtful if material of such value could be assembled from any other source in the country.

"If the Governor wants this material, all he need do is ask for it. However, this does not mean that the California Medical Association is acting as co-sponsor for any plan which might be evolved from the use of such facts and figures as we may be able to furnish. The House of Delegates of the California Medical Association has gone on record officially as opposing any compulsory health insurance plan which has so far been presented to it, including the outline of Governor Warren's plan as announced in the press and as given directly by the Governor to the Council of the Association."

Dr. Gilman detailed some of the reasons why the medical association is against a compulsory health insurance plan at this time, laying particular stress on the manpower shortage and the impracticability of setting up such a system under wartime conditions.

"The Californai Medical Association went on record in 1938," he said, "as favoring a system of health insurance. That was when California Physicians' Service was organized. This service has only recently emerged from the statistical study period encountered at the outset and has gained the knowledge of how a widespread health insurance plan can be operated with satisfaction to both the patient and the doctor.

"If we now attempt to extend such practices to a compulsory health insurance system and saddle the doctors and the patients with a new set of regulations and further payroll deductions, we are facing an immediate breakdown of the entire system of medical care in California.

"In the first place, there is grave doubt that sufficient manpower could be found to staff the administrative offices necessary in a Statewide compulsory plan. In the second place—and this is where the doctors are directly concerned—there are certainly not enough doctors in California to handle the additional medical work which would be thrown upon their shoulders if such a plan were instituted.

"The doctors of California and of all other states are working at top speed today. The death rate among the physicians is climbing because of overwork, long hours and the attempt to care for all cases which really demand attention.

"Now the Federal Government is talking about drafting nurses and thus cutting off one of the mainstays of the doctors' offices. The burden in doctors' offices is already too great and any compulsory health insurance plan which is added on the top of the present medical structure can only bring a collapse.

"The California Medical Association has offered an alternate solution for immediate adoption. It has suggested that workers who are out of employment because of illness be granted unemployment benefits from present unemployment funds. Such benefits would help to ease the burdens of loss of income, and medical and hospital expenses for the employed person.

"At the same time, the California Medical Association has gone on record as recognizing that a problem exists in the distribution of medical care and has suggested that a joint committee of physicians, dentists, labor, management, government, agriculture, hospitals and others be established immediately for the purpose of conferring on a complete and comprehensive plan to cover the entire problem of health service in California. Invitations to all groups concerned will be issued by the California Medical Association within the next few days for a joint meeting to be held, if possible, within the next two weeks."

Aid in Health Plan Offered

Doctors Ready to Help Write Insurance Bill

The doctors of California are ready to give Governor Warren "any requested assistance" in writing his proposed health insurance bill despite the fact that the doctors have officially gone on record as opposed to the plan, it was announced here yesterday by Dr. Philip K. Gilman, president-elect of the California Medical Association.

Pointing out that "the Governor has not requested the association to give him help on his proposed bill," Dr. Gilman said the association nevertheless "is ready and willing to supply any technical details which the Governor may request."

Doctor Gilman offered "a mass of actuarial data" accumulated "through our experience of the past six years with California Physicians' Service." The Governor can have the material, Doctor Gilman said, although "this does not mean that the association is acting as cosponsor for any plan which might be evolved from the use of such facts and figures as we may be able to furnish."

Doctor Gilman detailed reasons why the association is against a compulsory insurance plan at this time, laying particular stress on the manpower shortage and "the impracticability of setting up such a system under wartime conditions."—San Francisco *Examiner*, January 12.

Doctors Can Help

It is encouraging to note the gesture of the California Medical Association in offering to assist Governor Warren and the Legislature in their study of the subject of compulsory health insurance. The medical profession can supply much information of value in connection with this matter.

Also, the Association's plan to hold a joint meeting of doctors, labor representatives, business management leaders and Government officials, including legislators, for thorough discussion of the subject should prove helpful.

In view of the recent recommendations of the Association's committee against compulsory health insurance, we assume the purpose sought to be achieved is education of these groups to oppose the plan. That is a perfectly legitimate way to proceed.

However, we wonder if the doctors may not by the same process, receive some education themselves that will open their eyes to the necessity and, perhaps, the wisdom of setting up a Statewide plan of medical care that will benefit everybody.

We hope their minds are open to this conviction, as they no doubt hope the minds of the people generally are to their point of view.

In his message Governor Warren said we have had plenty of studies and surveys, now the time has come for action. When last the issue became critical the medical profession met it by organizing the California Physicians' Service. But that plan has scarcely scratched the surface of the need. If, then, the profession is determined to defeat the governor's plan, it must come forward with something better. Failing that, we believe the doctors should truly coöperate to help work out a State plan that will be beneficial to the people and at the same time fair to the medical profession.

By its offer to participate in the Legislature's study, the California Medical Association has started in the right direction.—Editorial in San Francisco *News*. January 13, 1945.

Governor Warren Bares Details of Prepaid Medical Care Plan

Bills to Be Introduced Friday; Governor Admits Many Questions Unanswered

Examiner Bureau, Sacramento, Jan. 14.—First specific details of the proposal which is expected to develop the hottest fight of the 1945 session—prepaid medical care or "compulsory insurance"—were revealed today by Governor Earl Warren in advance of the anticipated introduction of the bill itself not later than Friday.

The Governor repeatedly has declared that he ranks his recommendation for prepaid medical care among the major issues in his 1945 program. He said the bill would be introduced simultaneously in both houses.

Assemblyman Albert C. Wollenberg, Administration leader and chairman of the Ways and Means Committee, will handle it in the lower house, and Senator Byrl Salsman in the Senate.

Highlights Outlined

Highlights of the program as outlined by Warren, based on the assumption that the legislature will accept the bill as drawn, include:

1. The system will go into effect at the beginning of 1947, with payroll deductions beginning six months earlier to build up a fund.

2. Payroll deductions will be 1½ per cent, taken from both employer and employee, against a maximum of $4,000 salary yearly. (Unemployment insurance taxes are assessed against the first $3,000.)

3. Contributions are expected to be deductible from both Federal and State income taxes.

4. Everyone covered by unemployment insurance will go into the prepaid medical care system automatically, and those not covered—the self-employed and farm laborers, for example—will be encouraged to come in on a voluntary basis. Everyone in the family of the worker will be entitled to medical care, not merely the member from whose check the contribution is taken.

5. Service will be on a "fixed fee" basis—so much per call at home or office, so much for various types of treatment, and so on through minor and major operations.

6. Hospital charges will be included in the benefits under the system.

7. Industries having their own private medical care or hospitalization programs, either with or without employee contributions, will be given an opportunity to come in to the State system.

Repeatedly in his long conference with newsmen today, Warren asserted that there is no intent to regiment the medical profession, or force the public to accept a single type of service.

Ceiling on Charges

While the fee system will be used, he said, rather than the capitation system which gives the doctor a fixed amount per month or year for each patient cared for, the "ceiling" on charges applies only when the service is paid for from the State fund.

In other words, wealthy persons could pay higher fees if they so desired, but no part of the fee, in such cases, could come from State funds.

"If a man is in the fund," Warren said, "and has so much money he does not want the same standard of care the average citizen gets, he can pay the doctor anything he pleases but he can make no claim in such case against the fund.

"The doctor cannot charge him $50 for a service carrying a $20 scheduled fee, collecting $20 from the fund and the remaining $30 from the patient. We don't want to mix the two.

"There may be some doctors who won't want to come into the system, who will want to continue treating only wealthy patients. That is perfectly all right with us. The same thing applies to certain hospitals which may prefer to remain outside the system, providing for wealthy patients.

Doctor's Choice

"The point we make is that when a doctor is operating under the State fund, he may collect only the fee provided in the fund. Otherwise there would be a tendency to drive standards down—to make people believe that State service is not adequate, and that by paying a little more, they could be better cared for."

* * *

Doctors need not "elect," however, to practice under the State system. They may have patients whose bills are defrayed by the fund, and other patients who prefer to pay heavier charges in the hope of getting superior medical service.

"We don't want to prevent doctors from having any type of practice they are entitled to," Warren said.

* * *

The "fee" system was preferred, Warren said, because of its greater efficiency in bringing the work of specialists into the system. The capitation system, however, will be proposed in amendments to be submitted by those favoring that plan.

The Governor explained that "we must have the fee system anyhow, for specialists, and we also need it to incorporate the services of dentists in the plan. Some services such as oral surgery are common to both professions."

Limited Dentistry

"While tooth pulling and more difficult types of oral surgery practiced by dentists will be included in the program," Warren indicated that tooth filling and denture making will not.

* * *

Questions too numerous to recount remain to be settled, Warren conceded. Many of them will be dumped into the lap of the administrative agency set up to direct the State's venture into compulsory health insurance. Others cannot be settled until experience provides the answer.

Among these questions are: Shall there be a waiting period before a migrant from outside California becomes eligible?

Shall a contributor to the fund, who has never drawn upon it for medical care, receive his money back when he leaves the State?

Shall the State make special provisions for the immediate admission of former servicemen and women into the system?

What can be done to prevent thousands of individuals from demanding immediate relief for their accumulated, long untreated ills as soon as the State system takes effect, which has been a major problem faced by many private and semipublic systems?

* * *

Warren ended a two hour "seminar" for newsmen by expressing the conviction that employers will benefit financially by the system—that they will reap rewards in increased efficiency and production when employees are healthy, and are relieved of worry over the health of their families.—R. W. Jimerson, in San Francisco *Examiner*, Monday, January 15, 1945.

California Health Insurance Program

Payments Under Warren's Plan Will Start in 1946, Benefits to Begin in 1947

Sacramento, Jan. 14.—Collections from employers and employees and others to finance Governor Warren's pro-

posed health insurance program will begin in 1946 and payment of benefits will commence January 1, 1947.

The Governor announced these facts today in making public for the first time some of the important provisions tentatively agreed upon for inclusion in the Warren "prepaid medical under a compulsory health insurance system" bill to be presented to the legislature this week.

The program will include medical, dental and hospital care to those contributing to the system and to members of their families

Bill to Be Introduced

"We hope to introduce our bill in both houses of the Legislature the latter part of the week," said the Governor.

Senator Byrl R. Salsman, Palo Alto, and Assemblyman Albert C. Wollenberg, San Francisco, will handle the legislation in their respective Houses.

Governor Warren said many important points are yet to be settled in connection with the final draft of his bill.

The following broad principles have been agreed upon:

1. Cost of health insurance will be met by a payroll contribution of 1½ per cent by both employer and employee or 3 per cent by a self-employer or other person who wishes to join the system.

2. Inclusion of all persons currently under unemployment insurance but with the tax applying only on the first $4,000 of annual income.

3. Payment of doctors and dentists on a fee basis with fees varying for different types of service.

4. Permitting continuation of existing voluntary health insurance programs where they meet State standards, but requiring payroll deductions for the State fund, regardless of any payments to the private fund.

5. Complete freedom of choice between patient and doctor.

6. Fixing of a "ceiling" only on medical fees that are paid out of the State fund.

7. Contributors to the State system who desired to pay doctors higher fees than those allowed by the State program would not be entitled to receive any portion of those higher fees from the fund.

No Side Agreements

8. Doctors would not be permitted to make "side agreements" for extra fees than those allowed by the State and continue to be eligible for State payments because of the danger medical service might deteriorate for those not paying the extra sums.

9. No exemptions from payroll contributions would be granted those wishing to be treated by a doctor not participating in the system.

10. Hospital charges will be included with a maximum limitation of time to be spent in a hospital.

11. Doctors electing not to participate in the State system could remain out.

12. Collections and payments to and from the health insurance fund to be handled by existing State agencies.

13. Establishment of an advisory governing board to determine policy and creation of a medical director to act as executive officer in administration of the health program.

The Governor said every survey he had seen "has indicated the majority of the medical men who are in the Armed Forces favor some kind of group medicine."

"I have preferred the fee system to the capitation plan," said the Governor.

Under the capitation plan doctors would receive a uniform payment of fees payable per capita for each of their patients.

"The capitation system," said the Governor, "would militate against inclusion of the dentists and medical specialists in the system."

Warren said he believed that where a person has been contributing to the health insurance system and leaves California before getting any benefits, he should be allowed a return of at least a part of his contributions.

Tax Deductions

Payments to the health insurance system would be allowable deductions against both Federal and State income taxes, the Governor said.

One of the "enormous problems which will be faced at first," said Warren, "will be the treatment of 'hypochondriacs'." He said medical men would have to deal with the problem themselves.

Chiselers, charlatans and similar persons might turn up in both the ranks of the doctors and the patients, Warren declared. But he believed the medical profession would do its own "policing" just as it does now.

Both houses of the Legislature resume sessions today following the week end recess.—Earl C. Behrens, Political Editor, in San Francisco *Chronicle,* Monday, January 15, 1945.

Governor Warren's Bill for Medical Care Periled

Competing Measures Threaten the Governor's Medical Care Bill

Sacramento, Jan. 15.—Governor Warren's proposed State compulsory health insurance program is in danger of being shunted off to an interim committee for protracted study . . . and there may be no action upon it at this session.

The Governor yesterday announced his bill, which will be introduced in the Legislature later this week, provides for collections from employers and employees during 1946 and commencement of benefit payments January 1, 1947.

One thing is certain: There will be plenty of controversy over health insurance. The Governor has said he believes that now is the time for action.

At present, it appears there will be a number of health insurance bills in addition to that to be introduced by Assemblyman Albert C. Wollenberg, San Francisco, and Senator Byrl R. Salsman, Palo Alto, in behalf of Governor Warren. The CIO is preparing a bill, and the California Medical Association, accordnig to Ben Read, its legislative representative, will have a measure before the session ends.

With the prospect of competing legislation, the way will be made easier to bottle up the Governor's proposal by urging further study and sending all of the proposals to another committee.

In the Senate, Senator Jesse M. Mayo, Angels Camp, will head an 11-member Welfare Committee, to which the health bill will be sent for its first hearing. Mayo has an open mind on the subject, but the make-up of the committee indicates the other 10 members may have some pretty fixed opinions on the proposal.

In the Assembly, Speaker Charles W. Lyon will send the Governor's bill to the Public Health Committee. Fred Kraft, a San Diego druggist, is chairman of the committee and has expressed himself as opposed to any compulsory health insurance bill.

Lower House Prospects

The make-up of the Lower House Committee indicates some of the members there also may be looking for an out so as to keep the Governor's program from being enacted. To call for further study would be one way of accomplishing this.

The California Medical Association has definitely declared itself to be against any "system of complete compulsion" and will offer legislation providing for further expansion of voluntary physicians' service organizations.

The Association is expected to seek legislation providing for the payment of unemployment compensation during periods when employees are out of work because of illness and to provide for the reduction of pay roll taxes for unemployment purposes in those cases where employees are already enrolled in voluntary health programs.

The so-called "liberals," however, who have been shouting for progressive legislation will find themselves hard put to vote against the Governor's bill if it ever gets to the floor of the Legislature.

To clear the decks for early study of the Governor's 1945-47 State budget, which will be presented this week, Chairman Wollenberg of the Assembly Ways and Means Committee today organized his committee; 14 subcommittees made up of the 25 members of Ways and Means will devote themselves to the budget. The subcommittees include general administration, agriculture, corrections, education, the University of California, fiscal affairs, industrial relations, institutions, military affairs, motor vehicles, natural resources, social welfare, Department of Justice and water resources. . . .

Additional items recommended by Governor Warren were included in bills introduced today. Assemblyman John C. Lyons, Los Angeles, presented bills putting domestic help and agricultural workers under unemployment insurance and also making employers of one employee come under the unemployment insurance system. At present, an employer is excluded unless he employs four or more persons.

The two bills were not presented as administration measures, however.

(The Associated Press estimated that the two measures would expand the unemployment act to bring nearly 400,000 additional workers under its provisions. The State Employment Department said that the measure would affect 150,000 workers for employers hiring less than four people; 75,000 domestic and 169,000 agricultural workers. If those self-employed in agriculture were included an additional 130,000 would be affected. In June of last year 2,204,000 were subject to the act.) . . .
—Earl C. Behrens, Political Editor the Chronicle, in San Francisco *Chronicle*, January 16, 1945.

California Health Insurance

Six Bills to Go Before Legislature; Doctors, Labor Back State Program

Sacramento, Jan. 17.—The Legislature will have at least six health insurance bills before it at the current session.

In addition to Governor Warren's program to be embodied in a bill expected to be ready for introduction next week, there will be two measures sponsored by the California Farm Bureau Federation, one by the Democratic majority bloc in the Assembly, another by the CIO, a bill by the California Medical Association and two or three others.

Senator Geoge J. Hatfield, Merced county, will author the two bills of the Farm Bureau Federation.

Von T. Ellsworth, representing the federation, states there is no conflict between the Farm Bureau plan and Governor Waren's since farmers are not now covered by unemployment insurance.

The first of the Hatfield measures provide formation of health service associations by doctors and laymen. It would be a voluntary rather than a compulsory service except that all organizations providing medical care on a periodic payment basis would have to come under its provisions.

County Hospitals

The second bill relates to the use of county hospitals. It would authorize boards of supervisors to adopt a policy of admitting any and all county residents to be hospitalized in county hospitals and to charge for such services on the basis of the patient's ability to pay.

The Democrats are waiting to see what Governor Warren's bill covers before bringing in their measure. One proposal made by the Democrats is that the cost of compulsory health insurance be split among the employer, employee and the State. The Governor's program calls for a 1½ per cent pay roll contribution from employer and employee.

The Democratic bill may also contain the capitation system of payment whereby a doctor receives so much per capita for the care of each person who is his patient. The Governor favors a fixed fee payment plan.

CIO Favors System

The CIO bill will propose the capitation system of payments rather than the fee system.

Senator Fred Weybret, Monterey county, will father a bill permitting formation of hospital care districts.

The California Medical Association bill will not be presented for several days.

Meantme, Dr. Ernest Sloman of the California Dental Association conferred here today with Assemblyman Albert C. Wollenberg, San Francisco, who will handle the Governor's health bill in the lower house. Sloman favors the general program outlined by the Governor. . . .
—Earl C. Berens in San Francisco *Chronicle*, January 17, 1945.

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COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (17)

Contra Costa County (7)

Bernstein, S. L., *Pittsburg*
Gray, A. Bernard, *Richmond*
Loewenstein, Hans G., *Pittsburg*
Mills, Martin, *Richmond*
Moran, James A., *Richmond*
Rea, Stanley L., *Richmond*
Riklin, Henry H., *Richmond*

Riverside County (1)

Eilers, Paul G., *Riverside*

San Francisco County (6)

Bartlett, Alexander G., *San Francisco*
Buerger, Walter Richard, *San Francisco*
Downing, George C., *Carlisle Barracks, Pa.*
Durfee, Raphael Burke, *San Francisco*
Langley, Ivan Ira, *San Francisco*
Modley, Betty D., *San Francisco*

Santa Barbara County (2)

Gibb, William Blake, *Santa Barbara*
Day, Jane M., *Santa Barbara*

Santa Clara County (1)

Ehrhart, John D., Jr., *San Jose*

Transfers (1)

Behneman, Harold M. F., from San Francisco County to Riverside County

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Hill, Reuben Chandler. Died at Coalinga, November 20, 1944, age 69. Graduate of the University of California Medical School, Berkeley-San Francisco, 1901. Licensed in California in 1901. Doctor Hill was a member of the Tulare County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

McAulay, Martin. Died at Monterey, November 3, 1944, age 69. Graduate of the Hahnemann Medical College of the Pacific, San Francisco, 1904. Licensed in California in 1904. Doctor McAulay was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Orella, Fermin Ralph. Died at San Francisco, December 4, 1944, age 76. Graduate of the Cooper Medical College, San Francisco, 1892. Licensed in California in 1893. Doctor Orella was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Sellery, Albert Clifton. Died at Long Beach, November 24, 1944, age 69. Graduate of McGill University Faculty of Medicine, Montreal, 1904. Licensed in California in 1906. Doctor Sellery was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Smith, Ralph Merle. Died at Glendale, November 28, 1944, age 57. Graduate of the College of Medical Evangelists, Loma Linda, 1916. Licensed in California in 1916. Doctor Smith was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Turner, Jesse Harold. Died at La Canada, November 20, 1944, age 48. Graduate of Loyola University School of Medicine, Chicago, 1927. Licensed in California in 1927. Doctor Turner was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA PHYSICIANS' SERVICE†

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Rt. Rev. Thos. J. O'Dwyer, Los Angeles

Beneficiary Membership

	September 1943	September 1944
Commercial Program	50,620	90,000
Rural Health Program	2,400	2,011
War Housing Program	26,336	15,560
Total Membership	79,356	107,571

✣

On an over-all basis, the significant event of California Physicians' Service appearing before the Pepper Committee on Wartime Health and Education will be of interest. A report of this is in the October issue of California and Western Medicine, on page 207. It will suffice to state here that C.P.S. was the only medical service plan in the nation which was invited to appear. It is also to be noted that a Pepper Field Investigating Committee will probably come to the West Coast during the coming months for further detailed study of C.P.S.

In general, C.P.S. is beginning to expand rapidly, as evidenced by the rate of acquisition during the past three months:

August	10,012 persons
September	7,127 persons
October	23,079 persons
Total	40,218 persons

C.P.S. continues to pay its $2.25 unit value, but has drawn heavily from its reserve, due to the high incidence of surgery during summer months, in order to maintain this. At the last meeting of the Board of Trustees, held November 19th, Mr. Ralph R. Nelson, the actuary who

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M.D., Medical Director.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

has been retained by C.P.S. since its inception, reported on the first solid year of experience under C.P.S.'s new *Surgical Contract*. This report revealed that the rate of the present use of service and the dues for beneficiary membership would not develop the goal of the $2.50 unit value. Consequently, it was recommended that our rates be increased to meet this. The Board of Trustees unanimously approved this recommendation, as contained in the following resolution:

WHEREAS, For the past year, and since the readjustment of medical and surgical benefits, the Board of Trustees of C.P.S. has been concerned with the inability of its present dues structure to produce sufficient income to meet the necessary costs of operation and services; and

WHEREAS, The Board has withheld action for approximately one year in order to permit its actuary, Mr. Ralph R. Nelson, to complete a study of experience; and

WHEREAS, Mr. Nelson has now completed such comparative study and has reported that either (a) dues must be raised, or (b) service to members curtailed; and

WHEREAS, After extended discussion the Board rejects any reduction of service as incompatible with adequate medical care, and therefore must raise dues of beneficiary members in an amount necessary to produce sufficient income; now, therefore be it

Resolved, Beneficiary membership dues are hereby revised as follows:

Surgical Coverage:	$.80	per month per man
	1.20	per month per woman
	2.00	per month for two-person family
	3.00	per month for three or more person family
Medical Rider:	.90	per month

And be it further

Resolved, That, with respect to new members, said revised dues shall be effective from and after December 1st, 1944, and that with respect to existing members, dues be revised as soon as possible under present contractual commitments; and be it further

Resolved, That the officers and administrative staff are hereby instructed to notify all professional and beneficiary members and all other interested persons of the terms of this resolution, and carry same into effect.

Significant administrative changes have occurred.

C.P.S. has created the position of an *Assistant Director*, who will have charge of the entire Southern Area, and it has also changed the operations of the Medical Department in the South with the employment of a full-time physician.

* * *

A new department has been created within C.P.S., which is beginning on an experimental basis, and which has been temporarily designated the *"Department of Professional Relations."* The function of this department is to contact physicians in their offices, and also talk with their nurses. Routine calls are being made upon all physicians, and definite gains have been made in the understanding of the C.P.S. program.

The attitude of the medical profession toward C.P.S. is evidenced by a noticeable diminution in the number of complaints from beneficiary members. This is evidence that physicians are rendering better service.

Most of the County Medical Societies have accepted the proposal from the C.M.A. that all new members of the County Society be acquainted with the principles of C.P.S., so that they may decide whether or not to become professional members. Since the May meeting in 1943, over 240 doctors have become professional members, with the activities of increase more evident during recent months, 63 new members having joined in October—the highest month since the organization of C.P.S.

Through the kindness of certain key physicians in several communities, the administrative staff has been offered the opportunity to sit down with groups of physicians, including nonbelievers, those without any particular concern and proponents of C.P.S. These discussions have been invaluable in acquainting these men with the history, problems and philosophies underlying California Physicians' Service.

With reference to the *recent action by a group of Alameda physicians* enjoining physicians in that area to resign from C.P.S., there have been gains and losses, but the net has been a loss of only seven physicians, leaving a total of 289 professional members still remaining, which is sufficient for us to give adequate service. . . .

T. HENSHAW KELLY, M.D.,
Secretary.

* * *

(COPY)

CALIFORNIA PHYSICIANS' SERVICE
A Nonprofit Corporation

Dear Doctor:

The California Medical Association, County Medical Associations, and Professional Members of California Physicians' Service have united their efforts to assist C.P.S. in its Professional Membership Drive.

We need the support of every physician if we are to meet successfully our mutual problems.

If a physician in your community is not a member of C.P.S. will you urge him to join now? Please write us if you should want an application form and other descriptive material.

Thank you for your coöperation in this new professional membership drive.

Very sincerely,
A. E. LARSEN, M.D.,
Executive Medical Director.

* * *

C.P.S. Beneficiary Members

(Report for January "C. & W. M.")

	October 1943	*October 1944*
Commercial Program	51,350	93,000
Rural Health Program	2,400	2,011
War Housing Program	20,867	15,200
Total Membership	74,617	110,211

As we note in the beneficiary membership statement, C.P.S. has now passed the 100,000 mark. This membership has been obtained in the face of a continuing labor turnover, which of course affects membership in C.P.S. Since C.P.S. deals only with groups, naturally the activities in those groups will affect C.P.S. accordingly.

There seems to be a growing interest on the part of industry and labor, and with the renewed support of the medical profession, our representatives are having less and less difficulty in obtaining large groups in old-line industries which, while expanded during wartime, will still be sizeable postwar organizations.

The recent pre-optimistic reaction to the war situation has not only affected our Commercial Program, but has had a much greater effect on our War Housing Program, which was to be expected. Migration from the temporary War Housing Project areas increased alarmingly during the latter months of the year, and in some areas—in particular, Vallejo—has seriously affected the continuity of the program.

At this writing, very significant events are occurring in the ranks of the medical profession, and there is considerable discussion about the place of C.P.S. in the future of medicine in the State of California. As developments occur, we shall keep the profession informed through this channel.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

War-Time Graduate Medical Meetings in California

The War-Time Graduate Medical Meeting Committee for Zone 24, which comprises the Southern Counties of California, has initiated a full-scale Graduate Medical Meeting program. The War-Time Graduate Medical Meetings are sponsored by the American Medical Association, the Amercian College of Physicians and the American College of Surgeons with the authorization of Surgeons General Norman T. Kirk, Ross T. McIntire and Thomas Parran.

The committee is composed of Capt. Harry P. Schenck (MC)USNR, of the U. S. Naval Hospital, Oceanside, California, Wayland A. Morrison, M.D. of Los Angeles, James Churchill, M. D. of San Diego, and Lt. Comdr. Geo. C. Griffith, (MC)USNR, Chairman, of the U. S. Naval Hospital, Corona, California.

Through the splendid coöperation of Capt. Jno. B. Kaufman, (MC)USN, District Medical Officer of the 11th U. S. Naval District, Capt. H. L. Jensen, (MC) USN, Medical Officer in Charge of the U. S. Naval Hospital, Corona, Capt. W. H. Leake, (MC)USNR, Chief of Medicine of the U. S. Naval Hospital, Corona, and Col. Verne Mason, MC, Medical Consultant, Office of the Service Command Surgeon, medical programs at bi-monthly intervals are presented in each of the following installations:

A.S.F. Regional Hospital, Camp Haan, Riverside
A.S.F. Regional Hospital, Santa Ana Air Base, Santa Ana
Birmingham General Hospital, Van Nuys
Camp Cooke, Lompoc, California
March Field, Riverside
U. S. Naval Hospital, Corona
U. S Naval Hospital, Long Beach
U. S. Naval Hospital, Oceanside
Torney General Hospital, Palm Springs.

Programs are planned along general medical and surgical lines. Programs in the specialties are scheduled at appropriately spaced intervals.

Faculty for this teaching program has been selected after careful consultation with the Commanding Officers of each of the Army and Navy medical installations, and especially through the help and advice of Dean B. O. Raulston of the Medical School of the University of Southern California and President W. E. McPherson of the School of Medical Evangelists.

Composing the medical staffs of the service installations in this district are many of the leading University teachers of this country.

Captain Morton Willcutts (MC)USN, Commanding Officer of the U. S. Naval Hospital, San Diego, is presenting to the doctors of San Diego and environs a splendid medical program each Thursday afternoon.

The civilian physicians in the neighborhood of each of the Army and Navy medical installations have been invited to participate in these programs. Announcements will appear at regular intervals giving subjects and speakers.

This educational program is being conducted for civilian as well as service doctors and we wish to keep them regularly posted of the lectures.

The central office of this committee is located at the U. S. Naval Hospital, Corona, and communications addressed to the committee should be sent to this address, directed to the Chairman, Lt. Comdr. Geo. C. Griffith, (MC)USNR.

War Death Toll of Doctors 326

Chicago, Jan. 11—(U.P.)—A total of 183 physicians died in military service during 1944, the *Journal of the American Medical Association* reported today, bringing the total to 326 since the war started.—San Francisco *Chronicle*, January 12.

U. S. Casualties Reach 646,380 Exclusive of West Front Loss

Washington, Jan. 11—(I.N.S.)—Secretary of War Stimson today promised to make public casualty figures reflecting losses in the German breakthrough in Belgium and France at his news conference next Thursday.

The past week, which he said reflected casualties early in December, showed an increase of 7,999 from the previous report. They represent figures compiled through December 29 but, Stimson explained, they reflect actual casualties of a period of two or three weeks earlier.

Cumulative figures since the beginning of the war now are 106,952 killed, 333,849 wounded, 64,283 missing, 59,267 prisoners of war, making a total of 564,351.

The War Department totals, added to the figures of the Navy, Marine Corps and Coast Guard, make a grand total of 646,370 casualties of all types.

Total naval casualties of today are 41,838, divided as follows: Dead 20,683, wounded 10,312, missing 8,307, prisoners 2,536.

Marine casualties total 39,328 as follows: Dead 10,186, wounded 26,292, missing 907, prisoners 1,943.

Coast Guard, total 862; dead 572, wounded 194, missing 97, prisoners none.—San Francisco *Call Bulletin*, January 11.

COMMITTE ON POSTGRADUATE ACTIVITIES†

Reginald Knight Smith Lecture

Mount Zion Hospital, San Francisco

Mount Zion Hospital, San Francisco, is inaugurating an annual lecture to be known as the *Reginald Knight Smith Lecture*, in memory of Dr. Reginald Knight Smith who served as Chief of the Division of Obstetrics of Mount Zion Hospital from 1909 to 1937, and in recognition of his outstanding medical service to the community.

Every year a prominent speaker of national medical repute will be invited to be the guest speaker on a subject of interest to the general medical profession preferably concerned with the newer developments in medicine. This year Dr. Philip Levine, formerly associated with the Rockefeller Institute and now Director of the Biological Division of the Ortho Research Foundation, Linden, New Jersey, has been invited to give the first lecture January 11, 1945, on the subject of Rh Factor, and Its Clinical Significance. Dr. Levine first published his work on this blood entity known as the Rh Factor in 1939 and later described the underlying causes of fatal hemolytic jaundice (erythroblastosis fetalis). It is known that a number of diseases, including many of the toxemias of pregnancy and repeated abortions and miscarriages, are due to the absence of the Rh Factor in the blood of certain women and its presence in their husbands and offspring. Children of an Rh positive father and an Rh negative mother may not only develop severe or fatal hemolytic jaundice (erythroblastosis fetalis), but may become mentally retarded because of injury to nuclei of their brains during gestation.

Dr. Levine received the Gold Medal award for his exhibition on Erythroblastosis Fetalis presented by the American Society of Clinical Pathologists in 1942. In

the same year the Mead Johnson Award was also presented to Dr. Levine for this original contribution. In 1935 Dr. Levine wrote the Wisconsin Law and in 1939 the New Jersey Law which authorized the courts in these states to order blood grouping tests in cases of disputed paternity. He has written numerous papers dealing with legislation on blood tests for non-paternity, individual differences of human and animal blood, and prevention of blood typing transfusion accidents. He has been on the faculty of the University of Wisconsin School of Medicine and a member of the staff of the Newark Beth Israel Hospital. He is a member of many academic and honorary societies, including Sigma Xi, American Society of Clinical Pathologists, Harvey Society, and the Society of Experimental Biology and Medicine.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Figures on Army Nursing Problem as Given by Dorothy Thompson in "San Francisco Chronicle"

The proposal to draft nurses has led this column to make a mathematical investigation. It furnishes startling testimony to the devotion and patriotism of the nursing profession, and raises the question of whether this matter cannot be better settled on a volunteer basis than by compulsion. Here are the facts:

The total of active trained American nurses is, in round numbers, 265,000.

Of these it is estimated 25 per cent are over the age of 45 and ineligible for army service.

That reduces the figure to about 199,000.

Army nurses may have no dependents. Of all women's professions, nurses have the highest marrying average. In 1943, when the last full survey was made, 40 per cent were married.

There are no figures available to show how many have children, but it is conservative to estimate there are 49,000.

If this is correct, then there are, altogether, only 150,000 trained nurses eligible for the services.

And 75,000 nurses have already volunteered for the armed forces, half the eligible nursing profession of the United States!

I submit that in no other profession of our population is there so high an average of the volunteer spirit.

Forty-three per cent of the 75,000 volunteers were rejected or released by the services for various reasons, most of them involving physical unfitness. The services demand women able to go anywhere, under any circumstances, with an extraordinary degree of physical, mental, and emotional superiority.

The procurement assignment service of the Manpower Board has found only 41,000 who can be considered eligible. None of these have gone through Army tests. Presuming they are no better nor worse than the 75,000 free-willers, the 41,000 would boil down to 26,800.

And what is actually needed is 10,000 with replacements at the rate of 250 a month.

I submit the question of picking 10,000 out of 26,800 does not require a draft service for all women. It is a matter of individual investigation and public education. . .

Trained nurses are essential in operating rooms. But neither in the Army nor in civilian hospitals are they essential for emptying bedpans, making beds giving baths, taking temperatures or administering prescribed medicines. One experienced trained nurse could train corps of men or women for such services, and rapidly.

Desperately needed are large numbers of nurses' aides, both in civilian and military hospitals here at home. Of Army nurses 70 per cent are overseas. The other 30 per cent could be immediately available for overseas service if they could be replaced by overage nurses, useless for overseas work, but perfectly able to nurse the wounded who have been returned. That, however, means more nurses' aides in both civilian and military hospitals here.

But it is doubtful whether you can successfully draft women as nurses' aides. Most nurses' aides are doing part-time work, for which no draft could provide. Thousands of married women who could arrange their household and family duties to enable them to work two or three days a week in hospitals—and this is what most nurses' aides are doing—would have to be dropped if the demand were made for their full time.

To issue an order and draft women seems to be quick and efficient. But in this particular case I fear it will be the least efficient and longest way to solve the problem.

"Res Ipsa Loquitur" In Malpractice

In a recent number of the *Bulletin* of the Los Angeles County Medical Association, appears the speech delivered by Marion P. Betty, Esq., at the meeting of the Los Angeles County Medical Association and Los Angeles Bar Association on Friday, September 29, 1944, at the Elks Club. Some excerpts follow:

Medical malpractice is the failure of a physician, undertaking the care and treatment of a patient, to possess or to exercise that reasonable and ordinary degree of learning, skill and judgment commonly possessed and exercised, by reputable physicians practicing in the same locality or in similar localities, in care of similar cases.

It also constitutes malpractice for the physician to fail to exercise his best judgment, at all times, in the care of his patient.

But the physician's best judgment must reach the required standard of that judgment commonly exercised by reputable physicians in similar cases in that or similar locality at that time. In other words, if the physician's best judgment fails to be equal to the common standard of reputable physicians, it is still malpractice, even though he exercises his best judgment.

The term, *res ipsa loquitur*, means, literally, "the thing itself speaks," but it is usually interpreted "the thing speaks for itself."

Res ipsa loquitur is a doctrine of the general law of negligence, but specifically it is a rule of evidence.

Originally the doctrine had no application to medical malpractice cases, but now it has been extended to such cases in most states. The trend is toward the extension of the doctrine in this field.

However, some states still do not recognize it.

In cases where the doctrine is applied it constitutes an exception to the general rule, which requires that the proof of a physician's negligence must be established by the testimony of qualified expert witnesses. . . .

Mercury is first referred to in the *"circa instans"* of Matthaeus Platearius (1140).

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see ***J.A.M.A.***, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In December, KFAC will present these broadcasts on the following Saturdays: January 6, 13, 20, and 27.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Philosophers Look to Scientists:* Columbia Univ. Press sponsors significant group of philosophical efforts attempting to apply implications of current knowledge to our faiths and beliefs: Ray Lepley's *Verifiability of Value* (N. Y., 1944, suggesting scientific basis for ethics); L. S. Eby's *The Quest for Moral Law* (ditto), and symposium edited by Y. H. Krikorian, *Naturalism and the Human Spirit* (ditto). But, alas, none refer to C. H. Waddington's *Science and Ethics: An Essay and a Discussion* (London, Unwin, 1942). The difficulties of western science in the philosophical development of the future are implied in the essays edited by C. A. Moore, *Philosophy East and West* (Princeton, 1944). The Princeton Press asks if you have discovered S. Kierkegaard (12 volumes available)? Seems to have been a rare Christian. A. E. Morgan offers fine appreciation of Edward Bellamy (1850-98), author of significant *Looking Backward* (Boston, 1888), issued by Columbia Press (N. Y., 1944).

2. *Blood and Shock:* E. Mylon, C. W. Cashman and M. C. Winternitz summarize succinate and plasma therapy of turniquet shock (*Am. J. Physiol.*, 142:299, 1944). I. H. Page describes cardio-vascular changes resulting from severe scalds (*Ibid.*, p. 366). J. E. Davis reports 3 oral doses 10 mgm./Kg. choline chloride daily reduces rbc's 30 per cent in normal dogs in 2-3 months and that liver or stomach orally corrects this hyperchromic anemia rapidly while atropine does so slowly (*Ibid.*, p. 402). A. E. Shaw & Co. emphasize hematocrit and plasma protein estimations in controlling infusions for shock therapy (*Med. J. Austral.*, 2:301, Sept. 16, 1944). Excellent symposium on blood: G. L. Taylor and R. R. Race and W. T. Morgan on blood groups and Rh; C. J. Britton on anemias; H. Scarborough on hemoglobinometry; and E. P. Sharpey-Shafer on dynamics of hemorrhage (*Brit. Med. Bull.*, 2:160-192, 1944).

3. *Choline enzymes:* J. F. Fulton and D. Nachmansohn & Co. suggest release of acetylcholine intracellularly depolarizes cell membrane rendering it permeable to all ions, thus generating action potential current to stimulate adjacent region; and show parallelism between choline esterase activity and voltage of action potential (*Science*, 97:569, 1943; 100:454, Nov. 17, 1944). F. Schutz shows high cholinergic activity is a factor in epilepsy (*Quart. J. Exp. Physiol.*, 33:35, 1944).

4. *Bacteriostatics and Antibiotics:* W. T. Salter gives full review of significance of antibiotics and bacteriostatics in blood and body fluids (*New Eng. J. Med.*, 231:651, Nov. 9, 1944). A. Winkler confirms local anesthetic inhibition of sulfonamide action (*Zntralb. bakt. parasit. infckt.*, 151:106, 1944). D. G. Evans & Co. find p-methyl-sulfonyl-benzamidine HCl highly useful IM aganist Cl. welchii and other gas formers (*Lancet*, 2:523, Oct. 21, 1944). Skin sensitization to sulfonamides locally may be treated and prevented by low dosage orally, say B. C. Tate and L. Klorfajan (*Ibid.*, p. 553, Oct. 28, 1944). M. J. Romansky and G. E. Rittman's method of prolonging penicillin action by IM injection of peanut-oil and beeswax mixtures (*Science* 100:196,

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

Sept 1, 1944), is confirmed by G. W. Raiziss (*Ibid.*, p. 412, Nov. 3, 1944), in suggesting single injection daily. A. H. Free & Co. offer evidence of effective absorption of penicillin from oral administration (*Ibid.*, p. 431, Nov. 10, 1944). M. Trumper and A. M. Hutter apply ice bag to area of penicillin injection to delay absorption and thus to prolong action (*Ibid.*, p. 432). See special penicillin issue *Brit. J. Surg.* (32:109-224, July supplement, 1944), with fine color pictures in E. Culter's article, and H. Florey's principles of treatment.

5. *Looking to a Happier New Year:* Our own C. M. Pomerat and L. Anigstein are first to offer experimental check on Russian anti-reticular cytotoxic sera (*Science:* 100:456, Nov. 17, 1944). Our own G. A. Emerson notes limiting effects of privine (*J. Pharmacol.*, 82:42, 1944). R. M. Stecher continues keen studies on mechanism of inheritance of Heberden's Nodes (*J. Clin. Invest.*, 23:699, 1944). P. Cristol & Co. note relative rapidity of hydrolysis of monohalogenated acetic acids, confirming probability of negligible toxicity if used as food and beverage stabilizers (*Bull. Soc. chim.*, 11:58, 1944; *Univ. Calif. Publ. Pharmacol.*, 1:397, 1941). Great group of sex hormone reports form appropriate memorial to Edgar Allen (*Yale J. Biol. Med.*, 17:1-349, Oct., 1944). Note 2nd Ed. M. A. Pei's *Languages for War and Peace* (S. F. Vanni, 30 W. 12th, N. Y., 1944, $5.00). Congratulations to Nobelates Dam, Doisy, Erlanger and Gasser! More next year!

Beaumont Memorial Foundation Brochure.—Organization of the Dr. William Beaumont Memorial Foundation is announced in a handsome brochure now available to members of the profession. The home of the foundation is at Prairie Du Chien, Wisconsin, where Dr. Beaumont carried on many of his history-making experiments. It is housed in a restoration of the old Fort Crawford Military Hospital.

The Foundation was organized as a memorial to the pioneer physiologist and as an American medical shrine. It is sponsored by a group of eminent medical men and community-minded Wisconsin citizens.

Officers and directors are: M. J. Dyrud, President; Dr. O. E. Satter, Vice President; Dr. T. F. Farrell, Treasurer; J. A. Dru'yor, Secretary; Cal Peters, Curator. Medical Advisors are: Dr. P. L. Scanlon, Dr. H. H. Kleinpell, Dr. J. J. Kane, Dr. C. A. Armstrong, Dr. E. H. Lechtenberg and Dr. E. M. Dessloch. Directors: Dr. W. D. Stoval, Chairman of the Board, Dr. O. E. Satter, Dr. T. F. Farrell, Mayor F. W. Clanton, Mr. P. H. Schmidt, F. A. Otto and M. J. Dyrud.

Advisory Board: Dr. Walter J. Meek, Chairman. Members: Dr. Arno B. Luckhardt, Dr. Walter B. Cannon, Prof. Ben Elliott and Dr. Edward P. Alexander.

The announcement brochure gives an interesting history of Beaumont, the New England boy whose backwoods research and observations laid the ground work of modern physiological science. It carries many excerpts from Dr. Beaumont's diaries as well as his famous "51 Inferences."

Medical men may secure a copy of the booklet by writing the Dr. William Beaumont Memorial Foundation, Prairie Du Chien, Wisconsin.

NBC Radio Broadcasts.—Beginning January 6 and continuing through June 30, 1945, the American Medical Association and the National Broadcasting Company will present the twelfth consecutive season of nationwide network health broadcasts.

The title of the series for 1945 will be Doctors Look Ahead, including in the series broadcasts relating to wartime and postwar developments, with special emphasis on medical progress of the present day, and what it foreshadows for the nation's health in the immediate future.

Topics will be announced weekly in THE JOURNAL and monthly in *Hygeia*. Fast moving events may, however, cause last minute substitution of topics. Local newspapers should be consulted for announcements of time and stations. The program will be broadcast each Saturday at 4 p.m. Eastern War Time (3 p.m. Central, 2 p.m Mountain and 1 p.m. Pacific War Time). When conflicts exist with local programs, rebroadcast may be arranged at hours other than on the network schedule. The following are the topics for January:

January 6, Doctors at War.
January 13, Pneumonia.
January 20, Sulfa Drugs (Dr. Austin Smith).
January 27, Penicillin (Dr. Austin Smith).

The broadcast will be under the supervision of the Bureau of Health Education, whose director, Dr. W. W. Bauer, will summarize each program except when other speakers are announced.

American Society for the Study of Sterility.—Recently in Chicago the "American Society for the Study of Sterility" was organized. The new organization has for its objectives: 1. The encouragement of scientific investigation of fertility and infertility; 2. The improvement of the diagnosis and treatment of infertility; 3. The correlation and dissemination of the information obtained from these studies.

Among officers who were elected were John O. Haman, M.D., of San Francisco as Secretary, and Lewis Michelson, M.D., of San Francisco as a member of the Board of Directors.

Lederle Program Stations in Pacific Area—"The Doctors Talk It Over" is broadcast coast-to-coast every Friday, and may be heard in your vicinity over the stations and at the local broadcast times listed below:

CALIFORNIA

Bakersfield	KERN	1410 K.C.	10:30-10:45 P.M.	
Fresno-Visalia	KTKC	940 "	"	"
Los Angeles	KECA	790 "	"	"
Riverside	KPRO	1440 "	"	"
Sacramento	KFBK	1530 "	"	"
San Francisco	KGO	810 "	"	"
Santa Barbara	KTMS	1250 "	"	"
Stockton	KWG	1230 "	"	"
Watsonville	KHUB	1340 "	"	"

For the month of January, Nineteen Hundred and Forty-Five, in the Lederle radio program "The Doctors Talk It Over," the following guest speakers were on the program:

January 5, Karl Meyer, M.D., The Hooper Foundation for Medical Research at the University of California. Subject: "Psittacosis or Parrot Fever."

January 12, Wesley W. Spink, M.D., University of Minnesota Medical School. Subject: "Penicillin."

January 19, Paul Dudley White, M.D., Past-President of the American Heart Association. Subject: "Diseases of the Heart."

January 26, Thomas Francis, Jr., M.D., Professor of Epidemiology, School of Public Health, University of Michigan. Subject: "Outlook for the Control of Influenza."

These timely programs will be broadcast coast-to-coast over the Blue Network each Friday evening.

In working days lost per case, tuberculosis heads the list of unnecessary disabilities. This national loss is not due alone to doctors, nor the public health service, nor the ignorance and the carelessness of the people themselves. The blame belongs to all three.—Kendall Emerson, M.D.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Regulation of Medical Staff by Private Hospital: Admission of Emergency Cases

In the December, 1944, issue of CALIFORNIA AND WESTERN MEDICINE, the general principles governing the regulation of its medical staff by a private hospital were discussed. It was there set out that the rule in the absence of extenuating circumstances is that a private hospital has the right to exclude physicians from membership on its staff and from the use of the hospital facilities, and that such exclusion rests within the sound discretion of the managing authorities of the hospital.

Notwithstanding this right of a hospital to exclude physicians from the use of its facilities and therefore prevent their bringing patients into the hospital, there is the rule of law that a hospital is required to admit certain emergency cases regardless of who may be the attending physicain. It is important then to define what is meant by the word "emergency." To determine what is meant by the term "emergency" it is necessary to examine cases which have been decided in analogous situations, where it has been necessary for the court to define that term. The Medical Practice Act (in California, Business and Professions Code, Sections 2,000 to 2,496) in force in most jurisdictions requires an individual to be licensed before he can practice medicine. This rule is subject, however, to the exception that any person may render medical services "in cases of emergency." The cases decided under this Act are helpful in determining the meaning attributed by the courts to an "emergency case."

In *People v. Cosper,* 76 Cal. App. 597, the Court held that there was no emergency which excused the defendant in a prosecution for practicing without a license where the evidence showed that in a maternity case the defendant had treated the patient for a number of days and several hours had elpased before birth during which time there was ample opportunity to procure the services of a licensed physician.

In *William v. State,* (Neb., 1929) 224 N.W. 286, it was held that an emergency did exist when the exigency of an obstetrical case required some kind of action before the services of a physician could be readily procured. In that case an unlicensed assistant to the physician in charge had rendered medical services when the doctor was not available. The child was born twenty to twenty-five minutes after the defendant had arrived.

With respect to maternity cases, these two decisions indicate that a private hospital would be required to admit a patient as an emergency case where birth is imminent, but where there is ample time to obtain other hospital facilities, the patient could be refused admittance if attended by a physician not privileged to use the facilities of the hospital.

It is a general rule of law that if a physician operates or renders medical or surgical treatment to an individual without his consent, the physician is guilty of an assault and must respond to any damages suffered by the person treated. This rule is subject to the exception that medical and surgical care may be given without a person's consent in cases of emergency where immediate action is necessary to preserve the life or health of the patient. In determining the liability of a physician, the defendant in a court action for injuries suffered as a result of an operation without consent, the courts have held that a physician or surgeon is justified in applying such treatment as is reasonably necessary for the preservation of life or limb. Undoubtedly the same general rule would be applied in determining whether a private hospital was required to admit a particular patient as an emergency case even though the attending physician was not a member of the medical staff of the hospital. If the patient's condition was such that immediate hospitalization was necessary to save his life or to preserve his health, a private hospital would refuse admittance at its peril, and might be subjected to liability for any loss occasioned by the failure of the patient to receive immediate hospitalization.

The following are examples of cases interpreting the word "emergency" in applying the rule that operations without consent are justified in cases of emergency:

1. Where a fifteen-year-old boy had his foot crushed by a train and an immediate amputation was necessary to save his life the case was held one of emergency.

Luka v. Lowrie, 136 N.W. 1106

2. Where a boy of eighteen years had fallen from a train and suffered a severe gash in the head and a mangled arm, amputation of the arm without consent of the parents was justified as an emergency case, such action being necessary to save his life.

Jackovich v. Yocum, 237 N.W. 444

3. Operations to remove tonsils have been uniformly held not to constitute emergency cases which justify the physician in proceeding without the consent of the patient or his parents, if a child.

Coski v. Ganes, 271 Mich. 1;
Moss v. Risworth, 222 S.W. 225

4. The removal of membranous tissue from the thigh of the patient in order to afford sheathing for the tendons of a finger being operated upon was not justified on the ground of emergency.

Franklyn v. Peabody, 249 Mich. 363;
228 N.W. 681

5. No emergency exists which justifies operating without the patient's consent upon one ear where the patient has only consented to an operation upon his other ear when there was no immediate danger requiring such action.

Mohr v. Williams, 95 Minn. 261;
104 N.W. 12

Additional definitions of the word "emergency" are found in cases where a private physician or a hospital seeks to recover from the county authorities for medical services rendered to indigent persons resident in the county. It is generally stated to be the rule that a physician or a hospital may recover from the county authorities who are bound to provide such services to the poor even though the services were rendered without authorization from the county if they were rendered in "emergency cases." In this connection, it was said in *Cache Valley General Hospital v. Cache County,* 67 Pac. (2d) 639, that an emergency exists "not only where it is apparent that a patient will die unless cared for, but where the circumstances are such that it reasonably appears that there is urgent need of attention to save life." The following are some of the cases defining the term "emergency" in this regard:

1. Where an infection resulting from the amputation of a toe required the further immediate amputation of a leg to save the patient's life, the case was held to be an emergency. *Cache Valley General Hospital v. Cache County,* supra.

2. Acute appendicitis is uniformly held to constitute an emergency.

Lineback v. Board of Com'rs. of Potowatomie (Kan. 1924) 226 Pac. 993;
Dykes v. Board of Com'rs., 121 Pac. 1112

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

3. A broken collar bone has been held to constitute an emregency justifying immediate treatment without authorization from the county authorities.

Dykes v. Board of Com'rs., supra.

4. Severe burns resulting from an oil explosion and fire were held to create an emergency case requiring immediate treatment.

County of Madison v. Haskell, 63 III, App.

Although the above cases are helpful in demonstrating what courts have previously held to constitute emergency cases in various situations, it is impossible to prepare an exhaustive list covering all the cases with which a private hospital might be presented. Whether a given case is in fact an emergency requiring immediate hospitalization is at best a question of fact upon which physicians may differ. In order to avoid the possibility of litigation resulting from the death or other disability of a patient denied admission to the hospital, a private hospital should only refuse admittance to those cases which are clearly and obviously not emergency cases. If there is any possibility that the deprivation of immediate hospitalization will cause the patient to die or suffer aggravaton of his injury or illness, he should be admitted to the hospital regardless of who may be the attending physician.

LETTERS†

Concerning State Medicine in New Zealand:

January 15, 1945.

Dr. George H. Kress,
Editor, California and Western Medicine,
San Francisco, California.

Dear George:

The enclosed clipping I just received from some medical friends of mine in New Zealand where they have had State medicine for about five years and they are all very unhappy about it except the politicians and the labor unions and even the latter are disappointed. The medical profession there feel it is all a terrible mistake!

It is too bad that this legislation is being forced upon the medical profession in California while so many of us are in the military service and unable to protect ourselves.

With kindest regards,

(Signed by a C.M.A. Member in Medical Corps.)

* * *

Doctors Paid by State in New Zealand

Government's Intentions Outlined

The intention of the Government to encourage medical practitioners to work in coöperative groups under a medical service clinic system was mentioned by the Prime Minister, Mr. Fraser, and the Minister of Health, Mr. Nordmeyer, when replying to the discussion on the Social Security Fund estimates in the House of Representatives on Thursday. Mr. Nordmeyer said there was an increasing tendency, particularly among the younger members of the profession, to regard a State salaried medical service favourably.

The methods of paying the doctors were reviewed by Mr. M. H. Oram (Opposition—Manawatu), who urged that the system of requiring the patients to claim the refund of fees from the State should be instituted. He said there had been untold abuses under the system of the fee for service whereby the doctors claimed on the State.

Attitude of Doctors

The Prime Minister said he failed to see any difference in the opportunities for abuse between patients and doctors claiming on the fund. Owing to a changed attitude among the doctors many more of them were not now charging the patients, but claiming directly on the fund. He believed that the modern system of having clinics established with specialists working with practitioners would appeal to the profession.

Personally he thought the clinic system would be more efficient and in keeping with modern training. The doctors could be engaged either as employees of the State or be encouraged to establish coöperative clinics. He felt that more importance should be attached to the preventive side of medical treatment and that people should be encouraged to make constant and early consultations so as to prevent the development of diseases.

Referring to the medical services with the forces, Mr. Fraser said the British command had spoken most highly of the personnel and said there were no better hospitals at the front than ours. Mr. Fraser said he believed that many of these doctors, accustomed to getting a salary and not thinking of medical attendance in terms of income, had got a different outlook and would welcome a scheme where they would not be required to compete for a practice and could give their full services to the community.

The Minister of Health said that probably half of the amount paid for medical services was paid to doctors who accepted the 7s 6d for their consultations. He could not favour the suggestion of reverting to the system of making the patients claim, as it would penalize those now getting free service irrespective of which system was used to pay the doctors. The standard of service depended on the nature and character of the doctors themselves.

Under the present taxation incidence, continued Mr. Nordmeyer, if a doctor received income more than £3700 a year, then for every additional £1000 he earned he received only £100. In other words, for each extra consultation over and above that £3700 he received only ninepence. Those doctors who were drawing high incomes could not possibly give their patients the service they should, but that was largely due to the circumstances that many of our medical men were serving with the forces.

Many of the civilian doctors were greatly overworked, said the Minister, in citing instances. He also believed that many of the younger members of the profession were prepared to consider a salary service scheme through which they could get postgraduate studies, annual holidays and a superannuation scheme.

"We are working out a salary scheme today for those who are willing to come into it," said the Minister.

Refugee Practitioners

Mr. P. Carr (Government—Auckland West) pralsed the work of a number of refugee doctors, who, he said, had stepped into the breach when New Zealand doctors were unable to attend patients. He hoped the Opposition would not start out on a heresay hunt against them with the object of driving them out of the country.

The Prime Minister said that if some doctors were receiving £10,000 a year it would be a good thing both for the public and the doctors if the position were looked into.

Mr. Nordmeyer said there was no foundation for the statement that a refugee doctor was earning £5000 a quarter, nor were any refugee doctors earning more than £10,000 a year.

The Leader of the Opposition, Mr. Holland: But some doctors are getting more than £10,000.

The Minister said that it would be improper for him to give the incomes of a small group whereby it might be possible to identify them.—The *Weekly News*, Aukland, New Zealand, October 11, 1944.

Concerning Medical Journals and Books sent by C.M.A. Postgraduate Committee Hospital Stations of Military Camps in California*:

(COPY)

Station Hospital
Camp Calian
San Diego 14, California

November 7, 1944.

Dear Dr. Kress:

Thank you for your letter of October 31, 1944, regarding medical literature. Three packages mailed by you arrived and we wish to thank you for the magazines,

† California and Western Medicine does not hold itself responsible for views expressed in articles or letters when signed by the author.

* Recently, the C.M.A. Postgraduate Committee sent, prepaid, to Hospital Stations of military camps located in California, a total of 118 packets of medical journals and books, having total weight of 2,638 pounds. All Hospital Stations of military camps in California have also been placed on the complimentary mailing list of California and Western Medicine.

the two copies of "Social Security" and the Year Book on Radiology. Some of these magazines we already have, yet we will be able to use whatever you send.

I wish to express the appreciation of every medical officer here, as well as that of myself, for this splendid contribution. It is nice to feel that the California Medical Association is keeping the welfare of its members in mind who may be stationed within or without the United States. It is promoting the finest spirit of coöperation and will aid materially in helping the work which we do at this hospital.

I wish to thank you for your offer of the loan of library material and I can assure you that we will be happy to avail ourselves of it.

Gratefully and fraternally yours,

(Signed) Merle S. Harmon,
Lt. Col., MC,
Post Surgeon.

(copy)

Army Service Forces
Ninth Service Command
Headquarters Mitchell Convalescent Hospital
Camp Lockett, California

C.M.A. Postgraduate Committee,
San Francisco, California.

Gentlemen:

We wish to express our appreciation for your offer of sending medical books and journals for the use of this station.

These books, when received, will be distributed to the members of our staff, and I feel certain that they will no doubt be interested in them.

We also wish to thank you for your having placed this station on the complimentary mailing list for your official journal, California and Western Medicine.

The staff will also be advised of your offer for loans of material from the medical libraries in California, which you listed in your letter of October 31, 1944.

For the Commanding Officer:

Donald Greely,
Major, Infantry,
Adjutant.

Concerning Proposal to Lower Medical Licensure Laws in California*:

(copy)

P. M. Savage, M.D., F.A.C.S.
San Bernardino, California

Dear Dr. Kress:

I wish to add my protest against the proposed plan of allowing all ex-army doctors to practice medicine in California upon a reciprocity basis.

We have sent some 40 doctors from our city alone—two of them my own sons—into the service. Myself and many of the other older men are hanging on and continuing the practice of medicine for two reasons only. One is that we feel it our patriotic duty and the other is to have a going practice to hand over to them when they return. If we over-supply California with doctors from other states we will be absolutely betraying a trust to our own men.

Thank you for your alertness in discovering and stopping this unjust procedure.

With kindest personal regards, I am,

Sincerely yours,

(Signed) Philip M. Savage, M.D.

* For discussion of this problem, see California and Western Medicine, for October, on pages 179 and 211.

Concerning "C. and W. M.," in Military Camps:

(copy)

Dear Doctor:

Have been at this station 6 months doing ENT chiefly, as well as some of the minor eye work. We are more than busy and are definitely short-handed as far as doctors are concerned.

California and Western Medicine that I receive is very much enjoyed by me, and by many of the men from the other States who read it, and praise its quality.

Kindest personal regards,

(Signed) Russell Fletcher.

Concerning Costs of Bubonic Plague Control*:

State of California
Department of Public Health

Dear Doctor Kress:

In answer to your letter of September 18, attached is a statement of expenditure of funds for plague control for the present biennium and the tentative budget for the coming biennium.

It is quite likely that a large amount of the funds requested for the coming biennium will be diverted to mosquito abatement as related to malaria control. I should say, roughly, one-half of the funds will be used in this way, should they be made available.

Very sincerely yours,

Wilton L. Halverson, M.D.,
Director of Public Health.

Concerning Increased Costs of Malpractice Insurance:

(copy)

San Francisco 4, November 18, 1944

Dear ————:

Your letter of November 10, 1944, addressed to Dr. George H. Kress, Secretary of the Medical Society of the State of California has been referred to us. My only suggestion with respect to the increased costs of malpractice insurance offered by Lloyds of London is that you might investigate the rates charged by other companies issuing malpractice policies. In addition to Lloyds of London which uses the standard form of malpractice policy approved by us, we have also examined and found satisfactory the policies issued by the Aetna Casualty & Surety Company and by the Medical Protective Society of Fort Wayne, Indiana. Policies issued by any one of these three companies would be satisfactory.

With respect to Dr. ———— who is in the military service, it has been our advice and recommendation that doctors in military service continue to carry malpractice insurance because of the possibility of malpractice action by an injured patient. The fact that a doctor may be in the military service does not absolve him from claims based on negligence which could be made by a soldier, sailor or other member of the military service treated by the doctor. Accordingly, we believe that Dr. ———— should have malpractice insurance.

In your letter you ask whether you should continue to carry insurance on Dr. ————. We assume that you do not mean insurance covering malpractice actions against the Clinic arising out of the acts of Dr. ———— while in the military service. We do not believe that insurance of this type would be necessary.

If you have any further questions, please feel free to call on us.

Very truly yours,

(Signed) Hartley F. Peart.

* For article on incidence of bubonic plague, see California and Western Medicine, for October, 1944, on page 218.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 1, January, 1920

EXCERPTS FROM EDITORIAL NOTES

1920 Resolutions.—There is a remote region where there are no coal strikes and where the atmosphere is most ardent that is described by sacred writers and theological commentators as a place paved with good resolutions. It is not the making, however, but the breaking of good resolutions that prepare them for such paving purposes. . . .

Resolute men and women who never let the native hue of resolution be "sicklied o'er with the pale cast of thought" have blazed the way in every useful field of human endeavor, particularly in the field of medicine.

During 1920 several acid tests will be applied that will determine the real interest that every ethical member of our profession in this State takes in the progress of scientific medicine. Measures will confront us on the 1920 ballot that are definitely designed to undermine the very foundations of scientific research and create chaos in the administration of our Medical Practice laws. . . .

During the year that has passed since Armistice Day there has been time to accumulate and appraise a large part of the valuable health lessons that have come out of the war. . . .

Let no one vainly try to do during 1920 what can only be accomplished by concerted effort. The biggest things in life cannot be accomplished by one individual playing a solitary game. It has been well said that the person who thinks he can get along without others is foolish, and if he thinks others cannot get along without him he is a fool.

As a permanent 1920 resolution, let us cultivate the coöperative spirit and all highly resolve, that by applying the helpful agencies known to modern medicine, we will make our part of the world a better place to live in, and that unselfishly and unflinchingly we will fulfill our professional and civic duties.

In this way we will not only initiate a new calendar but a new era of development.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Question of Improving Business Methods and Increase of Fees," by P. A. Jordan, M.D., San Jose, California.—Physicians as a class are untrained in business, and the physician's professional work is usually carried on in an unbusiness-like manner. His business methods may be improved by following the succeeding suggestions.

The arrangement of the physician's office is often not of the best. . . .

Having secured a good plant with which to carry on his business, it remains for the physician to sell his services to his patrons as truly as does the clerk in the department store. . . .

I think one of the most important points in the business life of the physician, and the one which is most often neglected, is a heart to heart talk with the patient at the time of his first visit. . . .

(Continued in Back Advertising Section, on Page 48)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

Only 37 applicants presented themselves for written examination at the October meeting of the Board. This examination was held in the Business and Professions Building in Sacramento. The results of said written examination will be released at an early date.

At the recent oral examination held in San Francisco 75 examinees presented themselves for oral examination These included physicians who had been licensed in other states more than ten years ago, as well as members of the armed forces, who applied on an examination not considered equal to the California examination given on the same date. This was one of the largest groups of oral examinees we have had. There was a higher percentage of failures in this examination than has been previously recorded.

The next written examination will be held in Los Angeles February 27-March 2, 1945. The next oral examination will be held at Elks Club, in Los Angeles, January 21, 1945.

The Board of Medical Examiners was ordered by the Superior Court of San Francisco on October 17, 1944, to restore the certificate of Lilly L. Koerber, previously revoked. The Board, in compliance with the Court Order did restore this certificate; however, an appeal has been filed which will be heard in the near future.

News

"Regular law and motion calendar of the fourth district court of appeal will be held next Tuesday at the court's San Bernardino headquarters, 263 Third Street. Fifteen cases are set for hearing, including the appeal of Dr. Clyde A. Pierson, appealing from a conviction of abortion. It is likely, however, that the Pierson case will be continued to the December calendar of the court of possibly to the January calendar in Fresno." (San Bernardino *Telegram*, November 9, 1944.)

"And now it's the 'green death'—add this term to the colorful demi-world expressions which have come into use among thrill-seekers to describe the modern drugs which they find can produce more of a jag than liquor. According to H. F. Dowdy and L. M. Bales, inspectors for the State Board of Pharmacy, who are engaged in a widespread campaign to curb illegal sale of the drugs, not only juveniles but many adults have taken up their use." . . . (Los Angeles *Herald and Express*, November 27, 1944.)

"On his plea of guilty in police court this morning to a charge of loitering around a school ground, Dr. Clarence H. Koennecke, 41, of 813 North Granada Avenue, Alhambra, had his case continued for sentence until next Wednesday morning. The suspect was released on $500 bail and Judge Kenneth C. Newell requested further investigation be conducted. Dr. Koennecke was arrested on

(Continued in Back Advertising Section, on Page 48)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



METAMUCIL

Metamucil softens the fecal residue, protects intestinal mucosa and exerts a gentle, stimulating, physiologic peristalsis.

Metamucil is the highly refined non-irritating extract of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

Metamucil mixes readily with liquids—is pleasantly palatable.

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should be done in every case of
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42 years under the same management
$2,600,000.00 INVESTED ASSETS
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Disability need not be incurred in line of duty—benefits from the beginning day of disability.
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Superintendent, V. W. OLNEY

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BOOK REVIEWS

(Continued from Front Advertising Section, Page 10)

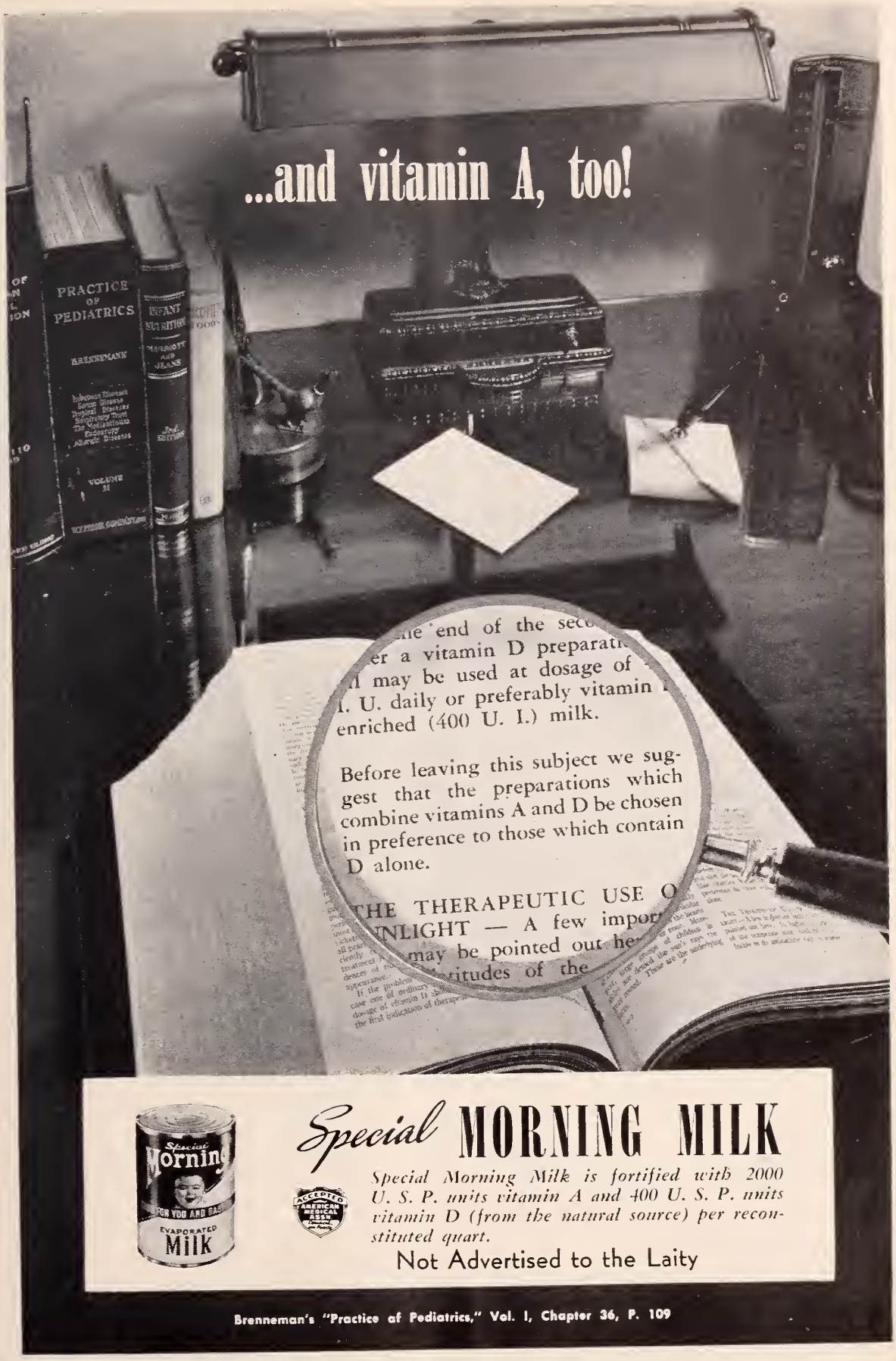
In a democracy the State is charged with the responsibility of providing educational opportunities for all children capable of receiving instruction. For such a problem there is no universal solution even for so-called "normal" children, because of individual differences. When to such recognized differences are added marked mental or physical deviations, the difficulties of finding a solution are increased.

One of the problems arising from marked physical deviations concerns the provision of educational opportunities suited to the needs of partially seeing children, whose vision difficulties prevent them from taking advantage of those offered the pupils with normal sight, yet who are equally misfits in schools and classes for the blind.

When classes were opened in New York City, they were called "sight conservation classes," a name which New York continues to use, whereas in other parts of the country the term has been shortened to "sight-saving classes."

The only name that seems acceptable to the great majority is "classes for the education of the partially seeing." It is a long and somewhat cumbersome title, but it does express the meaning and does not readily lend itself to misinterpretation.

The volume should be of value to those who are interested in visual problems.


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BRENNEMANN
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VOLUME II
end of the sec
er a vitamin D preparati
l may be used at dosage of
I. U. daily or preferably vitamin
enriched (400 U. I.) milk.
Before leaving this subject we suggest that the preparations which combine vitamins A and D be chosen in preference to those which contain D alone.
THE THERAPEUTIC USE O
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may be pointed out he
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Special Morning
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ACCEPTED AMERICAN MEDICAL ASSN.
Special Morning Milk is fortified with 2000 U. S. P. units vitamin A and 400 U. S. P. units vitamin D (from the natural source) per reconstituted quart.
Not Advertised to the Laity
Brenneman's "Practice of Pediatrics," Vol. I, Chapter 36, P. 109

Post-Surgical Starvation

with its wastage of body tissues, especially tissue and plasma protein, "begins almost at once after protein is omitted from the diet." Hence it is recommended* that meat and other protein foods be added to the diet as soon as possible after surgery. Meat is not only rich in protein, but its protein is of highest quality, able to meet every protein need.

*"Surgeons are accustomed to attribute most of the postoperative weakness or asthenia to the operative procedure without realizing that much of it may actually be due to starvation, particularly deprivation of protein . . . the fall in plasma albumin begins with the very onset of a protein deficient diet . . . Solid food, as eggs and meat, should be added as soon as possible. Most postoperative patients can eat food much earlier than they are usually permitted to." Elman, R.: Acute Starvation Following Operation or Injury: With Special Reference to Caloric and Protein Needs, Ann. Surg. 120:350-361 (Sept.) 1944.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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The natural vitamin A and vitamin D of time-proved cod liver oil itself—in the proportions typical of U.S.P. cod liver oil—are provided today, as for many years, in the three convenient dosage forms of

White's COD LIVER OIL CONCENTRATE

For infants, antirachitic prophylactic dosage of White's Cod Liver Oil Concentrate still costs less than a penny a day. Council-accepted, time-tested, widely prescribed—and promoted, without deviation of any kind, to the Medical Profession alone.

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Liquid—for drop dosage to infants
Tablets—for youngsters and adults
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White's PRESCRIPTION *vitamins*

Gelatum Alumini Hydroxidi

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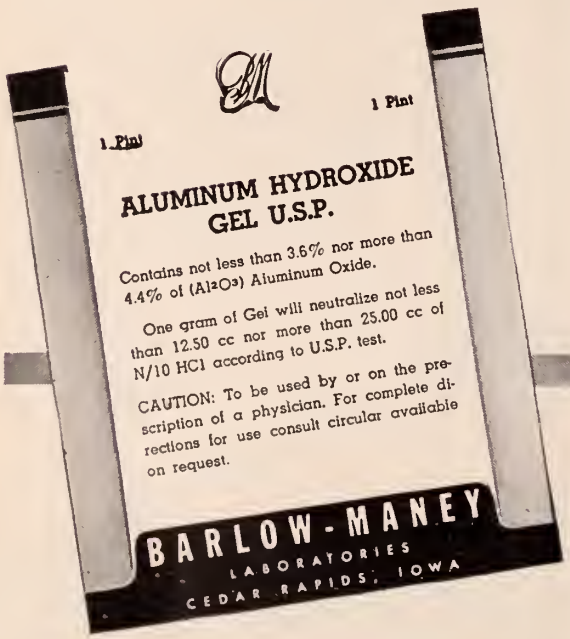
Unflavored (U.S.P.)

THE value of Aluminum Hydroxide Gel as an aid in the management of gastric hyperacidity has been established by ample clinical evidence.

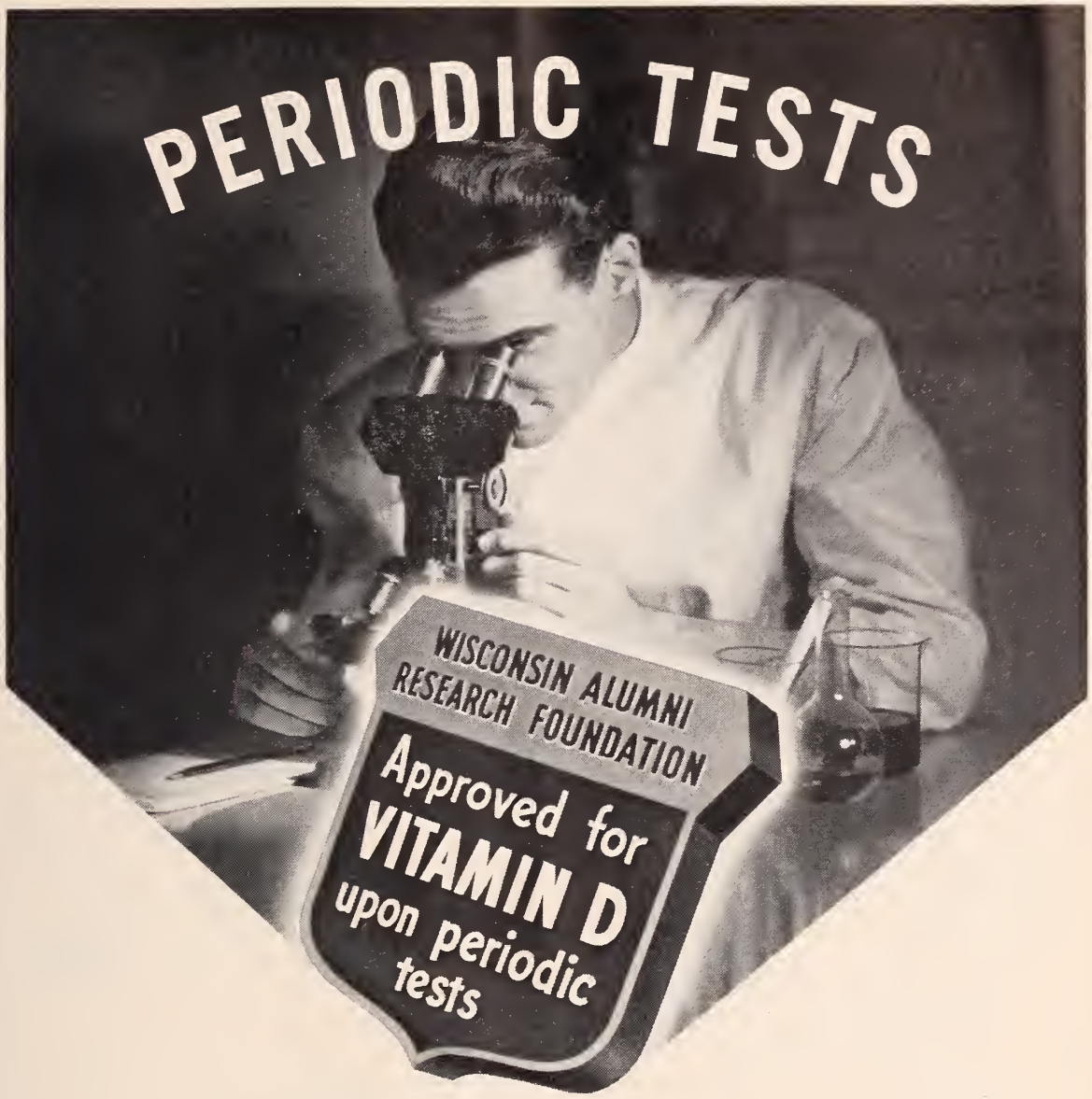
Barlow-Maney Aluminum Hydroxide Gel is prepared in accordance with the standards established by the United States Pharmacopoeia.

Flavoring agents are omitted as many gastro-enterologists feel that the inclusion in the formula of volatile oils or sugars may favor an increase in gastric secretion.

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There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phrenic nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
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Medical Director
COLFAX, CALIFORNIA

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Consultant in General Medicine

F. HARRY BENTEEN, M.D.
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EMILE HOLMAN, M.D.
(Stanford Hospital),
Consultant, Thoracic Surgery

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THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

Mercurochrome

(H. W. & D. brand of merbromin, dibromoxymercurifluorescein-sodium)

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

Complete literature will be furnished on request.



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Resident Clinicians

THE POTTENGER SANATORIUM and CLINIC

For Diseases of the Chest — *Monrovia, California*

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

(Established 1903)

CHOICE rooms and bungalows. Rates moderate and include routine medical and nursing services, interim physical, X-ray and laboratory examinations, ordinary medicines and pneumothorax. A charge is made for the first complete examination.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases. Separate institution for children.

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CALEVULATE INGRAM

A superior Calcium Levulinate preparation for parenteral use.

Whenever calcium salts are indicated, the Medical profession are finding Calevulate Ingram to offer outstanding advantages over ordinary calcium preparations.

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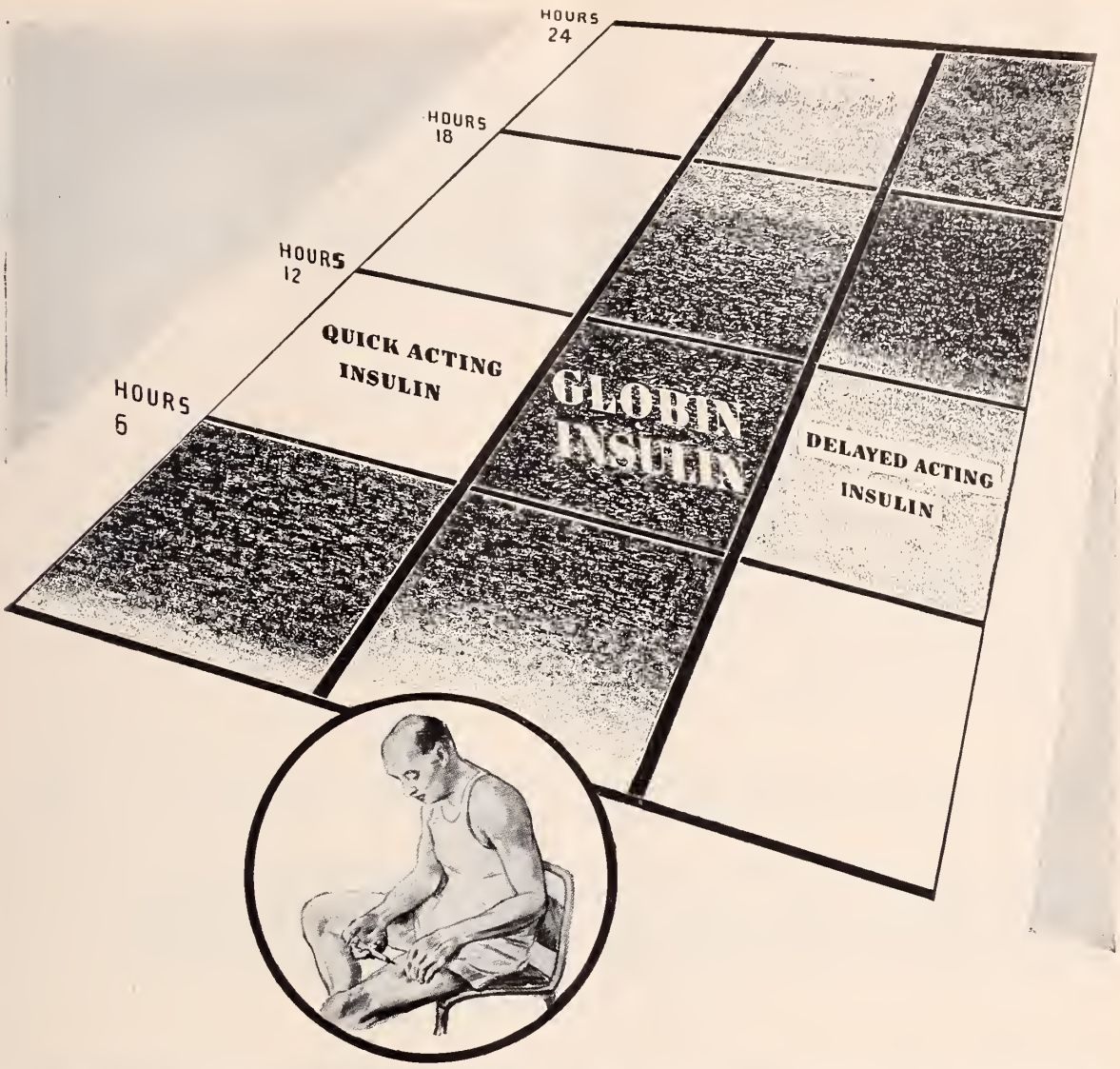


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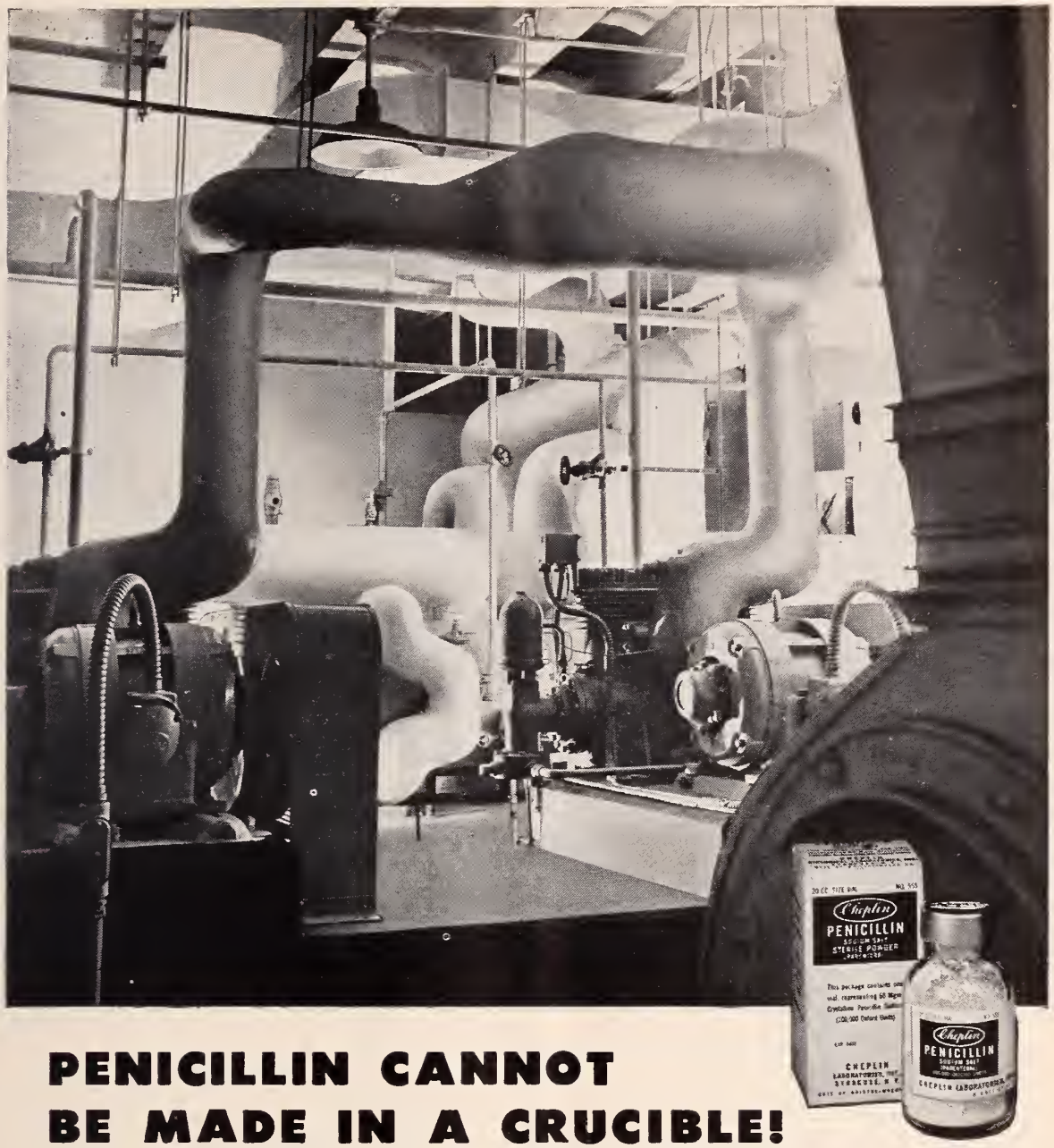
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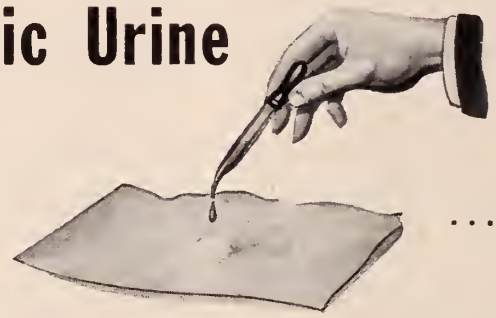
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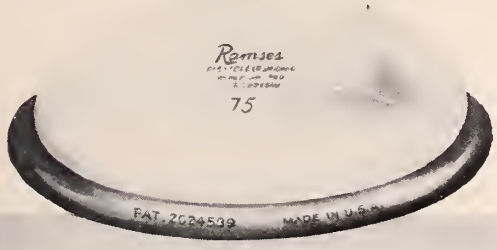
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(Continued from Text Page 50)

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(Continued from Text Page 50)

the Pasadena Junior College campus Wednesday night by Officer James Scott" (Pasadena *Star-News*. November 10, 1944.)

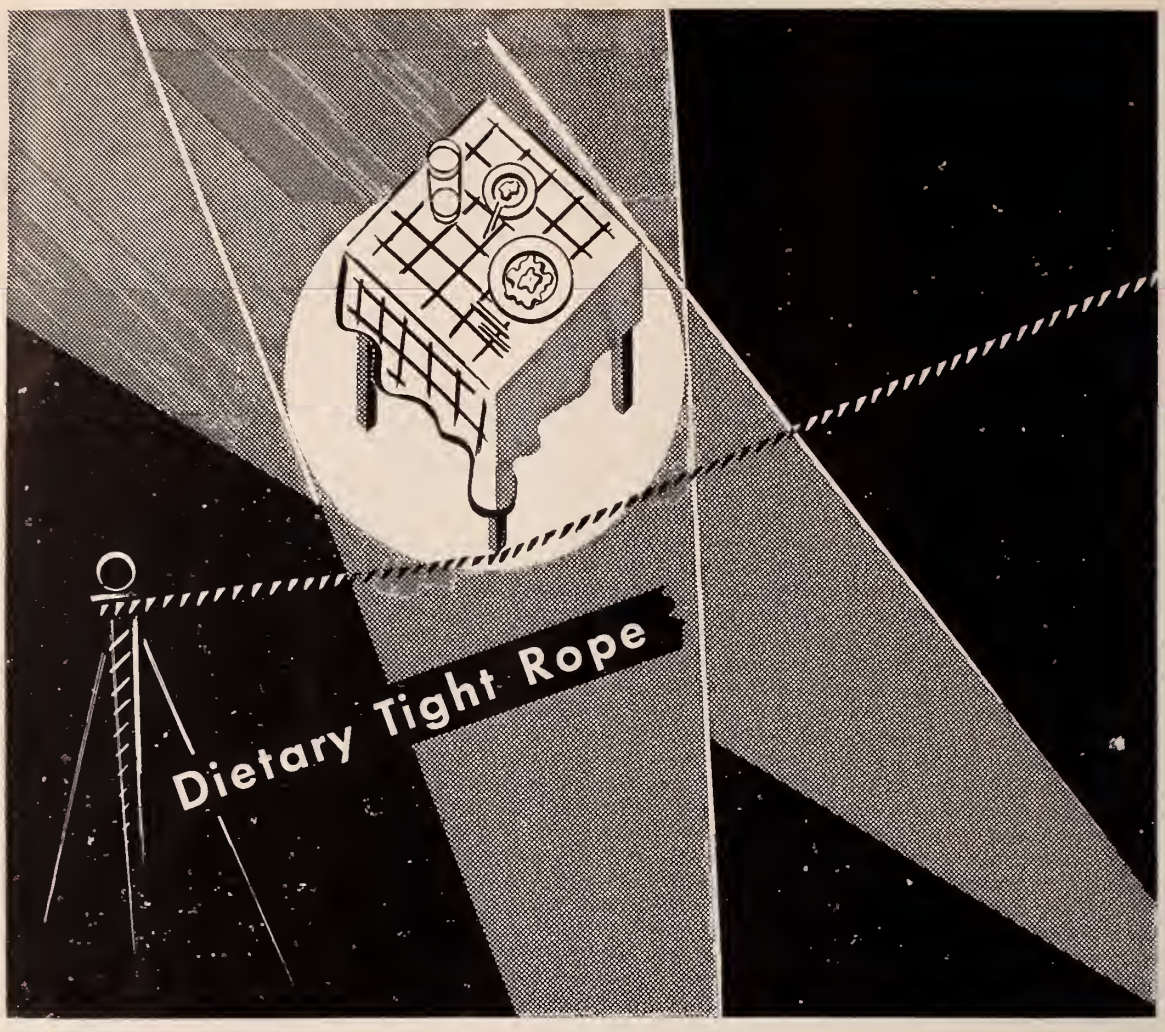
"Collaboration by the state's public hospitals to extend postwar postgraduate study facilities to doctors now serving with the armed forces as a means of bridging educational gaps made necessary by the war was suggested by Dr. B. A. Ralston, Dean of the Medical School of the University of California, last night . . ." (Fresno *Bee*, November 17, 1944.)



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"Our studies lead us to the conclusion that simultaneous administration of diphtheria, tetanus, and pertussis antigens has no disadvantages as compared with sequential administration. On the contrary, it has the practical advantage of lessening the number of injections necessary." Miller, J.J., Humber, J., and Dowrie, J.O.,: J. of Ped., Vol. 24, pp. 281-289, March, 1944.

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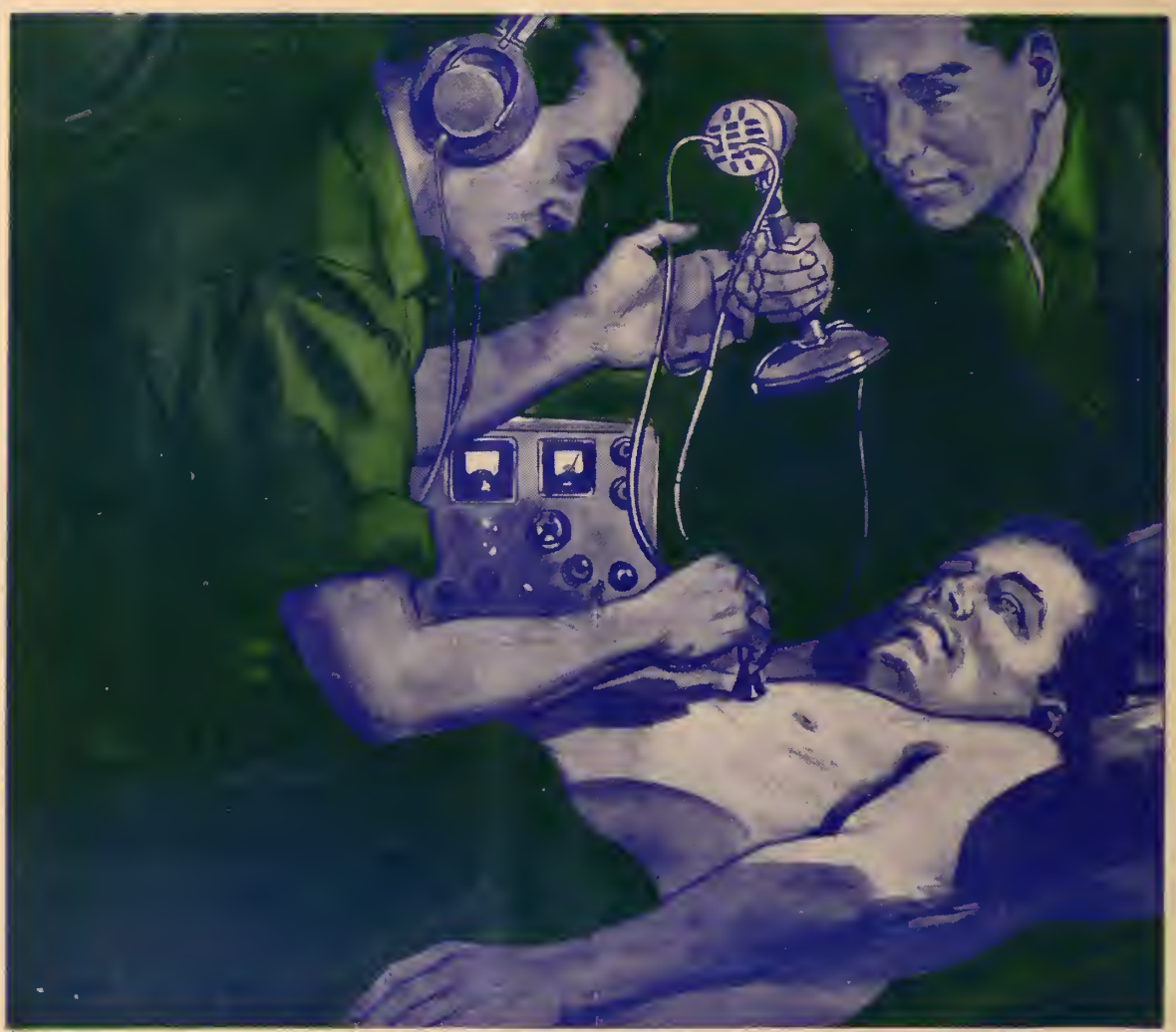
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University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

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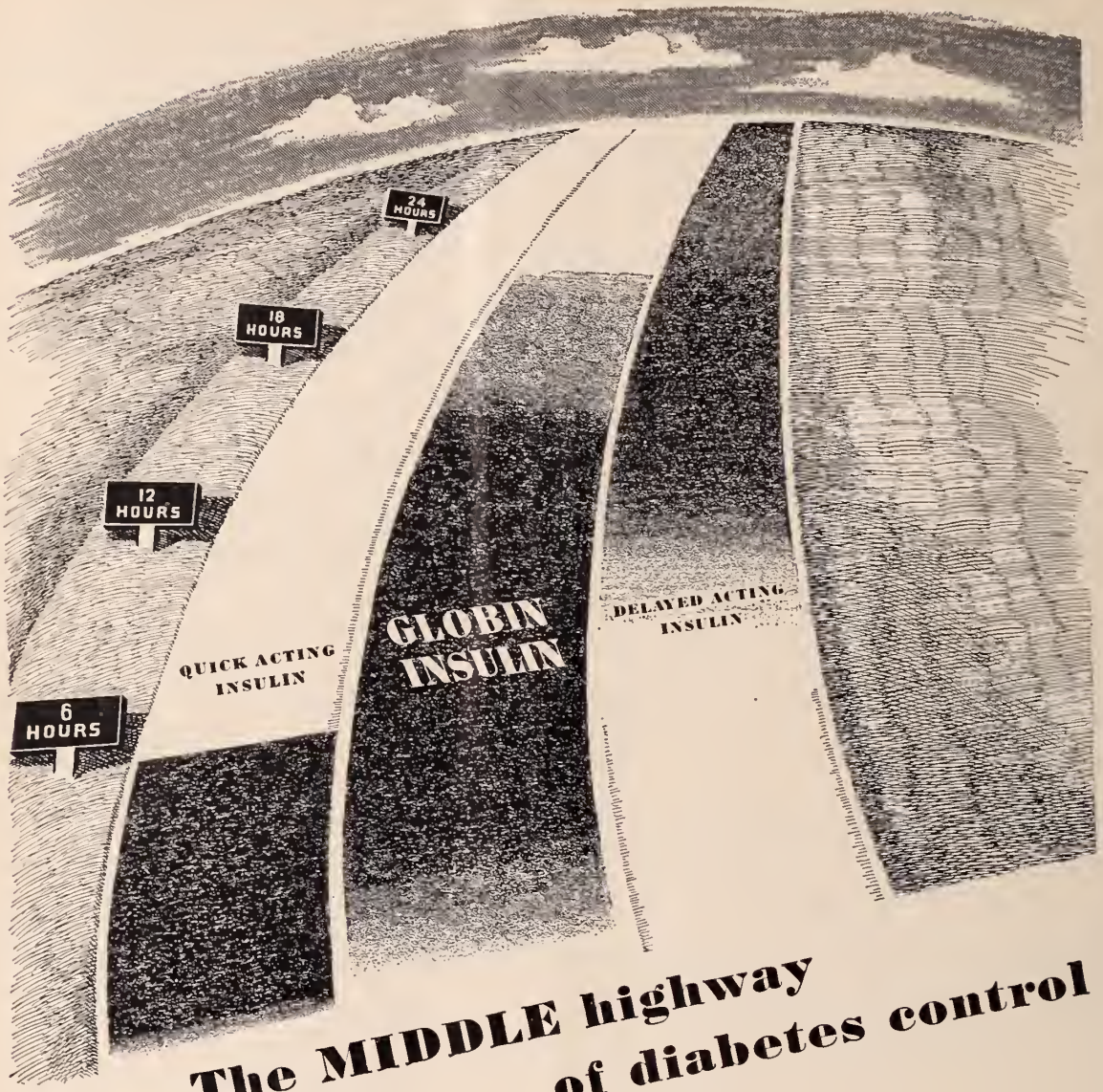
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The Pathology of Internal Diseases. By William Boyd, M.D., LL.D., M.R.C.P., Ed., F.R.C.P., Lond., Dipl., Psych., F.R.S.C., Professor of Pathology and Bacteriology in the University of Toronto, Toronto; Formerly Professor of Pathology in the University of Manitoba, Winnipeg, Canada. Fourth Edition, Thoroughly Revised. Cloth. Price, $10.00. Pp. 857. Illustrated with 366 Engravings and 8 Color Plates. Philadelphia: Lea & Febiger, 1944.

Arterial Hypertension. Its Diagnosis and Treatment. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D., Research Division of the Cleveland Clinic Foundation, Cleveland; Formerly Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis. Cloth. Price, $3.75. Pp. 352. Chicago: The Year Book Publishers, Inc., 1945.

The Etiology, Diagnosis and Treatment of Amebiasis. By Charles Franklin Craig, M.D., M.A. (Hon.), F.A.C.S., F.A.C.P., Colonel, United States Army, Retired, D.S.M.; Late Commandant, Army Medical School, and Assistant Commandant, Army Medical Center, Washington, D.C.; Emeritus Professor of Tropical Medicine, Medical School, Tulane University of Louisiana, New Orleans, La. Cloth. Price, $4.50. Pp. 332, illustrated. Baltimore: The Williams & Wilkins Company, 1944.

Medical Uses of Soap. A Symposium by Rudolf L. Baer, M.D., Acting Associate Physician at Montefiore Hospital for Chronic Diseases, and Assistant Attending Physician at the Skin and Cancer Unit of the New York Post Graduate Hospital of Columbia University; Irvin H. Blank, Ph.D., Visiting Research Fellow in Mycology, Harvard

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by

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*Reiter, P. J., Experience with Benzedrine, Ugeskr. f. laeger, 99:459-460, 1937.

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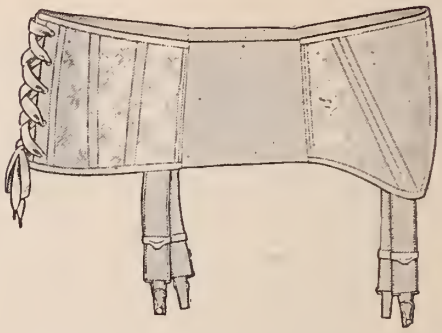
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BOOK REVIEWS

The Principles and Practice of Medicine. Originally written by Sir William Osler, Bart., M.D., F.R.C.P., F.R.S. Designed for the Use of Practitioners and Students of Medicine, by Henry A. Christian, A.M., M.D., LL.D. (Hon.), Sc.D., Hon. F.R.C.P. (Can.), F.A.C.P., Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; Clinical Professor of Medicine, Tufts College Medical School; Physician in Chief, Emeritus, Peter Bent Brigham Hospital; Visiting Physician, Beth Israel Hospital, Boston. Fifteenth edition. Cloth. Price, $9.50. Pp. 1498. New York, London: D. Appleton-Century Company, Incorporated, 1944.

The medical student, coming as he does to a consideration of clinical topics direct from his studies of bacteriology and pathology, usually thinks in terms of organic disease and speedily, when he begins to see patients, is surprised to find that so many of those that he

(Continued on Page 16)



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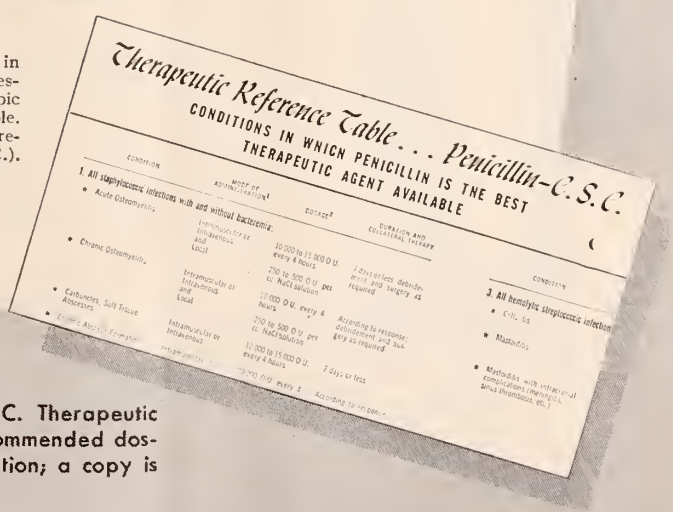
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BOOK REVIEWS

(Continued from Page 10)

sees, tell him concerning symptoms and reactions, little or no cause for which he is able to find in demonstrable lesions of body structures. The practicing physician early in his professional life comes to recognize this discrepancy and by experience learns how to cope with considerable success what he considers functional disease or functional aspects of organic disease. In times past the general practitioner, especially those in smaller communities, knew the antecedents and the backgrounds of his patients, as well as their past history and personality, and almost automatically utilized this knowledge in arriving at a diagnosis of their condition, and in planning a satisfactory and frequently, an entirely successful therapy.

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(Continued on Page 20)

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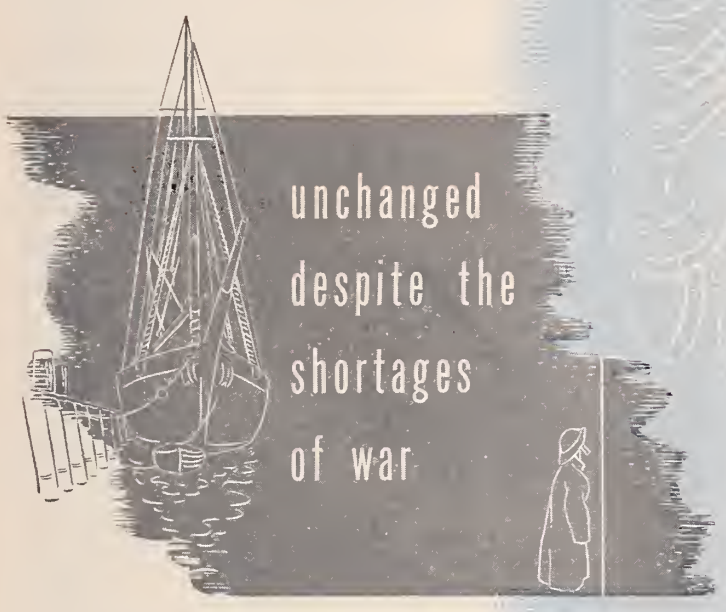
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BOOK REVIEWS

(Continued from Page 16)

generations of medical men practiced without much use of names for it.

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Man Does Not Stand Alone. By A. Cressy Morrison. Cloth. Price, $1.25. Pp. 107. New York, London and Edinburgh: Fleming H. Revell Company, 1944.

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(Continued on Page 26)



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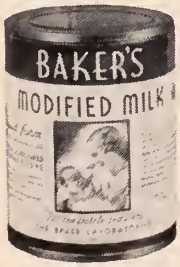
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BOOK REVIEWS

(Continued from Page 20)

up space for a radically changed conception of the universe and of reality. The deadly uniformity of discrete atoms no longer holds the imagination to the material, and the new knowledge leaves room for an effective intelligence behind the phenomena of nature.

(Continued in Back Advertising Section, Page 46)

TWENTY-FIVE YEARS AGO

(Continued from Text Page 102)

strengthening of the Medical Practice Act. . . .

The League during 1920 is called upon to conduct three State-wide campaigns in addition to its regular constructive work. An official League Bulletin will be issued to keep the membership in constant touch with these campaigns. and "to tell you what the League is trying to do for you and what the other fellow is trying to do to you.". . .

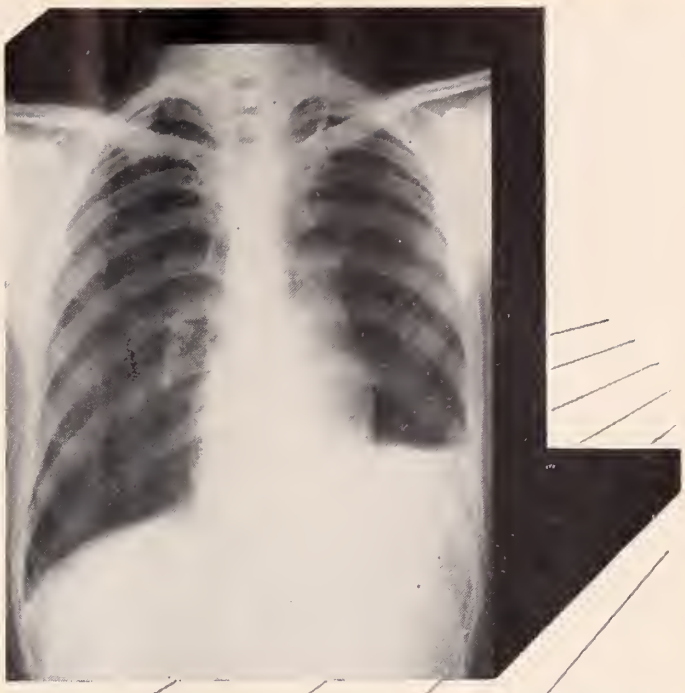
EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Botulism," by Ernest C. Dickson M.D., San Francisco.—The occurrence of several outbreaks of botulism within the past few months and particularly the prominence given in the press to two outbreaks which have occurred in the eastern states, has awakened active interest in the subject in all parts of the country. It is now generally accepted that botulism is a type of food poisoning which must be seriously considered by all who undertake the preservation of perishable foods, and it has become necessary to make a careful survey of the methods used in preserving foods to ascertain whether they will insure destruction of the spores of Bacillus Botulinus should they happen to be present in the raw material. . . .

From an Article on "The Radiographic Study of the Abdominal Organs After Inflation of the Peritoneal Cavity," by Walter C. Alvarez, San Francisco.—As is well known, any part of the body may be made visible under the Roentgen rays if we can only make its degree of resistance to the passage of those rays different from that of the surrounding tissues. We may make it more resistant by injecting suspensions of barium or we may make it less resistant by injecting air. . . .

From an Article on "The Practitioner's Contribution to Embryology," by Arthur William Meyer, M.D., Department of Anatomy, Stanford University.—Human embryology could not have been developed without the coöperation of the practitioners in medicine. This could only fail to be true if midwives or others had donated the material from prematurely terminated pregnancies, to those specially interested in human embryology. Although, on rare occasions, midwives have coöperated with physicians and laboratory workers in this way, their contributions naturally have been of a very minor sort. However, if midwifery were properly controlled, or if midwives were properly organized, this need not remain true, for evidently they attend a very large number of cases of labor and undoubtedly learn of many

(Continued in Back Advertising Section, Page 30)



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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 62 FEBRUARY, 1945 NO. 2

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EDITOR GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

Francis E. Toomey	San Diego	1945
George W. Walker (Chairman)	Fresno	1946
F. Burton Jones	Vallejo	1947
Secretary-Editor	ex officio	

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Continued)

"Unhappy Days Are Here Again"—Re: Compulsory Sickness Insurance Laws.—Compulsory sickness legislation again confronts the medical profession of California. Recurrently, during the last thirty years, the physicians of our State have had this experience. However, in this year, 1945, the threat is more serious than ever before. That fact should be taken to heart by every Doctor of Medicine who wants high standards of medical practice to remain available to the citizens of California.

When the present 56th California Legislature started its one-month recess on January 26th, four major compulsory sickness bills had been submitted:

1. Assembly Bill 449, sponsored by the C.I.O.;
2. Assembly Bill 800, sponsored by Governor Earl Warren;
3. Assembly Bill 1200, sponsored by the California Medical Association;
4. Assembly Bill 1414, sponsored by Assemblyman Rosenthal. (This bill is identical with the measure proposed several years ago by former Governor Olsen.)

* * *

Story Is Told In Current Issue.—The story of the introduction of these and related bills may be gleaned, if one will glance at the many items which appear in the current issue of CALIFORNIA AND WESTERN MEDICINE, on pages 64 to 92.

* * *

No Apology For Giving Space to What Is Taking Place.—No apology is made by the Editorial Board for giving so much space to a description of the events that have led up to the proposed legislation. If medical practice, as formerly and now conducted, is to have its best elements and procedures preserved and kept in operation, it will be necessary for every member of the California Medical Association to appreciate the significance of certain impending changes that now threaten the proper maintenance of the public health.

Defeat lies ahead, if the medical profession fails effectively to educate the public concerning the menaces involved in some of the legislation that has been proposed.

Physicians who have been in the habit of giving only scant or casual attention to laws designed to change the system of medical practice, now owe it to themselves and the profession to take time to read the stories that have come out of Sacramento, and to acquaint themselves concerning the dangers ahead. In this current number, on pages 64 to 92, those recitals, as presented by press representatives and others, are made conveniently available for perusal and consideration.

* * *

Strenuous Campaign of Education Is in Order.—By those who have given careful thought to the issues involved, it is generally held that if we are to prevent an arbitrary, foreign and undesirable system of medical practice from being thrust and inflicted upon the citizens of California, it will be necessary to carry on a strenuous campaign of education, both of the members of the profession and the public. It is also agreed that much of this educational work can be most efficiently carried forward through physicians themselves.

However, physicians cannot be good teachers unless they themselves are thoroughly familiar with their subject, and its ramifications. That is why it is so important that every member of the California Medical Association shall take the time to read and ponder the implications contained in the press and other articles referred to above, appearing in the current issue of the Official Journal and to be printed in future numbers.

The first chapter of the story of what is taking place at the present time, concerning proposed compulsory sickness insurance plans, appeared in the January issue of California and Western Medicine (pages 1 to 3, and 25 to 40). Physicians who failed to scan those accounts should now refer to this source material, if they would properly orient themselves. What may be called Chapter II of the story, will be found in the current number, on pages noted above.

* * *

Every C.M.A. Member Must Do His Part.—The Association's officers cannot carry on this battle alone. The active aid of every physician who respects himself and his profession is needed. If that coöperation and support are not given, it is quite within the range of possibility that State Assemblymen and Senators may enact adverse laws, or,—in case of referendum or other initiative,—the people of California may themselves bring into being a compulsory sickness insurance plan that would not only make for a lower quality of medical care, but must permanently demoralize medical practice as now carried on. This, not only for California, but possibly for other States in the Union.

* * *

C.M.A. Officers Have Called Attention to What is Taking Place. — The constituted authorities of the California Medical Association: (1) House of Delegates; (2) Council; and (3) Executive Committee,—through meetings, letters and other announcements have indicated to C.M.A. members the grave nature of the proposed laws, and have taken steps to inaugurate and carry through an aggressive campaign of education. However, the time to do this is short. Some of the opposnig forces have publicity and other facilities available that will be most difficult to combat. Delay is dangerous. Time is of the essence.

* * *

Public Is Being Rapidly Educated, but Often to the Disadvantage of Scientific Medicine.—The press items appearing in this current issue of the Official Journal should make clear to all how extensive has been the propaganda already given to the public. To purchase advertising space of amount and value equal to that of the news articles appearing on front and other display pages of newspapers, would necessitate an expenditure of some hundreds of thousands of dollars. (Granted, for argument's sake, that the advertisements would be read with the same interest as the news items?)

Before these controversial issues are settled at Sacramento, there will be a vast amount of additional and prominent space given to the subject by newspapers and discussion forums of the State.

It follows, therefore, that the citizens of California will form opinions thereon, and in due time probably will insist on some kind of action, through legislative or by initiative law, that will try to solve the problem, how to supply adequate medical care for citizens in the low-income groups of California. Such a law could be for better or for worse. Time would tell.

* * *

Public Is Opposed to Low Income Citizens Being Plunged into Bankruptcy Because of Illness.—One of the results of the large amount of publicity that has been given to sickness insurance plans, and already noticeable, is the opinion held by a majority of citizens of California, that many persons belonging to the lower income groups are unable to meet the costs of medical and hospitalization care of catastrophic illness. Almost everywhere the sentiment is expressed that something must be done to bring about a betterment, so that fellow citizens of small wage incomes may be able to secure medical and hospitalization care without involving themselves and their families in virtual bankruptcy.

As a guide for educational action, it is essential that this fact be recognized by physicians; and that proper effort be made, preferably under medical leadership, to indicate the procedures through which the need may be met.

* * *

High Costs of Hospitalization Care.—Living as we do, in a complex and highly interwoven and complicated civilization, the physician of today, in order to utilize his time to best advantage

in giving a proper quality of medical service, particularly in larger urban environments, must of necessity use hospitals and their facilities.

But hospitals, in one sense, are only hotels for sick instead of healthy persons; and, as such, necessarily must have larger numbers of skilled and technical employees, and greater amounts of specialized equipment. With nurses now working on eight hour shifts, the daily cost of hospital care in serious illness, if one or more members of a family of limited means are obliged to have hospital care for weeks, can easily impoverish it.

However, propagandists for compulsory insurance plans have given to the public the impression that hospital service is medical care, and that these high costs are primarily the fault of the medical profession! Therefore, according to them, the existing system of medical practice *must* be changed. Causative factors of illness, such as improper nourishment, vicious habits, ignorance, heredity, modes of living dependent on poverty, or illiteracy, are usually given very little attention by these propagandists who espouse a new social order in medical practice.

Hence, since the public, through such individuals and agencies, has already been educated to accept fallacious premises and conclusions concerning the economics and procedures of medical practice, the medical profession must now determine what steps shall be taken to overcome these erroneous impressions.

The task will not be easy. Physicians who are skeptical in regard to the above, should attend or listen in on some of the forum and round-table discussions at which these problems are considered, and note how well, in the paper and theoretical systems espoused, the proponents glibly put forth their alluring arguments for better medical care.

* * *

California Medical Association Bill Has Number A.B. 1200.—The bill sponsored by the California Medical Association (A.B. 1200) appears in full text in the current issue on page 65. A digest of its major provisions is given on page 91. See also items on pages 69, 73, 79, 81, 82, 83, 85, 89.

Comments are also made concerning the C.I.O. bill (A.B. 449), on page 89.

Governor Warren's measure (A.B. 800), is outlined on page 90.

The hope is expressed that all C.M.A. members will take the time to study the nature and scope of the proposed laws.

* * *

"Official Journal" Will Aim to Inform Members Concerning New Developments.—If there be readers of California and Western Medicine who would look askance at the amount of space now being allocated in California and Western Medicine to informative items concerning the proposed compulsory sickness legislation, it may be in order to remind such that the Official Journal of the California Medical Association is not primarily a publication to expound only the merits of Scientific Medicine, but is rather the printed medium through which the 7,627 C.M.A. members (of whom 2,168 are in military service) are to be kept informed concerning the activities of their Association, and the steps taken by its constituted authorities to conserve and promote the best interests of the profession and medical practice, and of the public health. For the time being, whether one or two or even a half dozen additional scientific articles are omitted from the pages of California and Western Medicine is of little moment compared to the larger interests at stake in the proposed legislation.

* * *

C.M.A. Members Should Send Suggestions to State Councilors.—As stated in previous issues, component county societies and their members should feel free to communicate their suggestions and views on these subjects to C.M.A. Councilors and General Officers. With unity of outlook and action, the profession of California will have far greater chance of securing successful end-results in the issues now before us.

EDITORIAL COMMENT†

ANTIFIBRINOLYTIC THERAPY

In 1933 it was discovered by Tillett and Garner[1] that beta hemolytic streptococci produce an exotoxin capable of liquefying human fibrin. Patients convalescent from beta hemolytic streptococcal infections usually develop an antiserum capable of neutralizing this fibrinolysin. Tillett[2] subsequently reported evidence that this streptofibrinolysin is presumably not a proteolytic enzyme. During the course of studies of the clinical significance of convalescent antiserums, Mirsky[3] and his associates of the Army Air Field, Lincoln, Nebraska, were struck by the parallelism between the antifibrinolytic and antitryptic titers of such serums. This suggested the possibility that fibrinolysin is more closely related to trypsin than previously assumed, and that antitryptic therapy might be of value in limiting the local spread of beta hemolytic streptococcal infections.

Two antitrypsins were available for tests: (a) the crystalline "trypsin inhibitor" isolated from beef pancreas by Northrop and Kunitz,[4] and (b) the soybean antitrypsin recently described by Ham and Sandstedt.[5] Both were tested for their effects on in vitro liquefaction of human fibrin by beta hemolytic streptococci filtrates. It was found that as little as 1 mgm. of the pancreatic inhibitor would delay liquefaction of solid human fibrin from the control period of 39 minutes to

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department No presentation should be over five hundred words in length.

as much as 3.5 hours, and that 5 mgm. would delay fibrinolysis for as long as 63 hours. They found that this inhibitor would not only neutralize strepto-fibrinolysin, but in higher concentration would also inhibit aseptic antolysis of human fibrin. Grob[6] had previously shown that the pancreatic inhibitor also retards the rate of proliferation of hemolytic streptococci. The soybean inhibitor had similar properties, but was somewhat less effective, 5 mgm. delaying fibrinolysin for but little more than 24 hours. Both pancreatic and soybean antitrypsins are nontoxic when injected in relatively large doses into the peritoneal cavity of mice or guinea pigs.

Mirsky's studies lend support to the belief that the strepto-fibrinolysin is a proteolytic enzyme closely related to trypsin, and that the antitryptic titer of the blood is of clinical significance in streptococcal disease. If so, it should be possible to limit the spread of beta hemolytic streptococcal infections by regional or systemic administration of either pancreatic or soybean antitrypsin. The clinical value of this suggested possibility is now under investigation.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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OF MICE, AND MEN AND WOMEN

Despite the gains in medical practice attained by animal experimentation, every new experimental fact must span the abyss between species.

In 1913 Loeb showed that ovariectomy at an early age reduced the incidence of spontaneous breast cancer in mice. From that time on, a vast amount of research on the relation of both endogenous and exogenous estrogens to the genesis of breast and uterine cancer in mice has been accumulated. The exact mechanism of the estrogenic stimulus remains unknown. Some clinicians have earnestly asked for experimental guidance in determining the safe therapeutic dosage of estrogens. Others have warned against overdosage, and indiscriminate dosage. Still others have brushed aside the experimental evidence as something peculiar only to mice. Few planned critical experiments can be done on humans. However, significant observations occur incidental to custom, or in association with unrelated events. Such has been the case in regard to the proliferative responses from estrogens.

The estrogenic stimulation of the female genital tissues in aplasia and atrophy is generally recognized. It has also been observed that the benign tumors—fibro adenomas of the breast, myomas of the uterus and ovarian cysts—arise during the period of active ovarian function. Carcinoma of the breast and of the uterus have been reported as occurring frequently in association with a delayed menopause (i.e., after 50 years).

Carcinoma of the breast coincident with strenuous estrogen therapy has been reported three times. Causal relationship would be almost impossible to prove. From the nature of the cases, they are not likely to be published. One hears of other examples, and occasionally finds one concealed in the literature. An anonymous registry for such cases might help to accumulate enough data to unravel the significance of isolated observations. In its pathology as well as its physiology the breast is a secondary sex organ. Study of it as part of the sex endocrine system is a fruitful though neglected clinical subject. A similar association of adenocarcinoma of the uterus with estrogenic therapy has been noted.

Three editorials on the injudicious use of estrogens have appeared in the *J.A.M.A.* Quite recently the *J.A.M.A.* has published three articles on the rôle of injudicious endocrine therapy in the delayed diagnosis of uterine cancer, on the management of cases predisposed to adenocarcinoma of the uterus, and on the control of cancer of the uterus. The emphasis of these articles is not so much one of warning of danger, as one of hopefulness that early diagnosis and cure of these cancers can be made if their antecedent and associated manifestations are watched as significant changes.

Massive estrogen therapy is deliberately used in treating cancer of the prostate. Pain and enlargement of the breast is not an unusual observation in the course of this treatment. As far back as 1942 the British Journal of Surgery reported the development of a "dangerous degree" of chronic mastitis in two male workers in stilbestrol. The *J.A.M.A.* of January 13, 1945, records the histological confirmation of the clinically noted chronic cystic mastitis in the course of estrogen treatment for cancer of the prostate. Since cancer of the prostate cases will receive the most massive estrogenic therapy of any human group, and the doses will probably be highest before the optimum use is evolved, these cases offer a unique opportunity for bridging the chasm between research and practice. Every opportunity should be presented to study this material.

Breast cancer has been reported as following shortly after the diagnosis of granulosa cell tumor. About 10 per cent of the cases of granulosa cell tumor have coexisting adenocarcinoma of the uterus. When one recalls that the estrogenic potency of granulosa cell tumors varies, and so does their duration before operation, and that case follow-up is not always maintained, this figure seems of etiological significance.

(Concluded on Page 61)

ORIGINAL ARTICLES

Scientific and General

MALPRACTICE ACTIONS: WHO STARTS THEM?*

Louis J. Regan, M.D., LL.B.
Los Angeles

ALMOST every unjust malpractice claim is precipitated by a physician. If physicians were always able to obtain perfect results there would, of course, be no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Any patient with less than a perfect end result is a potential malpractice claimant. Whether or not such a patient brings an action is often determined by his feeling toward the physician.

Patients who have a friendly feeling for the physician and patients who believe that everything possible has been done for them are not so likely to sue for malpractice, even in bad result cases. It is otherwise if the patient is resentful of some fancied or actual affront, if he believes he has not been sufficiently closely attended, or above all if some third person raises a doubt in his mind as to the propriety of the treatment.

ELEMENTS IN PATIENT PSYCHOLOGY

Certain elements of patient psychology as factors in malpractice causation have received too little attention. Although the patient presents himself sick or injured to his physician, he nevertheless visualizes himself as he was, prior to becoming sick, with his body structures intact. If the patient has a Colles fracture, he compares the final result with his wrist as it was before the injury, not with the wrist he presents to the physician. Again, the average patient is not prepared to understand an error in diagnosis or the failure to make an early diagnosis. We may agree that the surgeon faced with an acute abdomen cannot ordinarily delay operation until he can be certain of the diagnosis; if he does, mortality rates rise.

We have a case of this sort now in which a surgeon is threatened with suit. In this case after careful observation and investigation operation was performed on a diagnosis of Probable Appendicitis. The appendix proved to be normal. The patient was found to have acute Cholecystitis, and the gall bladder was removed. Unfortunately, the patient had a very stormy post-operative course. Another physician who thereafter came on the case was indiscreet in his remarks and suit is threatened.

PRECIPITATING OR EXCITING CAUSES OF MALPRACTICE SUITS

There are many unsolved problems in medicine. There are many conditions the cause of which is unknown. The importance of removing or controlling a causative factor is axiomatic.

In respect to malpractice we do know the precipitating cause. Almost every malpractice claim is instigated by a physician. That may seem to be a harsh statement but it is the truth. Unethical and destructive criticism by one physician of the professional care rendered a patient by another physician is the cause of most of the unjust malpractice accusations. Such criticism acts as a sort of virus which implanted in the mind of the patient produces, after an incubation period of varying length, the inevitable result.

We know the chief cause of this plague. However, the cause is not easily controllable. It seems that to refrain from criticism is almost beyond the power of some of us. Why is it that physicians are so prone to criticize their colleagues? There appears to be no simple answer to this question. There is no denying the fact, however, nor that the effects are deplorable.

It is not suggested at all that any physician should conceal or cover up an instance of actual malpractice whether on his own part or on the part of another physician. But that is not the point we are considering. The important questions to ask ourselves now are: can any physician fairly and ethically criticize the work of or the result obtained by another physician until and unless he is in possession of all of the facts of the case? Must he not have the story of the physician as well as the patient's story?

CONTRIBUTORY CAUSES OF MALPRACTICE SUITS

There are some contributing causes which should be mentioned in any discussion of the etiology of malpractice, particularly the following:

1. Failure of the physician to exercise tact in his contact with the patient and the patient's family.
2. Charging excessive fees.
3. The use of irritating fee collection methods.
4. Making over-optimtistic prognoses, promising too much to the patient.
5. The failure to prepare the patient for reasonably to be anticipated anatomical, cosmetic or functional defect or deficiency.
6. The delegation of duties to poorly qualified assistants beyond their capacity to perform.
7. The physician absenting himself without notice to his patients, and without arranging to have a well-qualified substitute available.
8. The failure to have a consultant see a patient who is complaining of his care or progress.
9. The making of statements which can be construed as admissions of fault.
10. The physician telling the patient that he has malpractice insurance coverage.
11. The failure to warn the patient against his unwise course when he does not follow advice, or discontinues treatment before he should.
12. The undertaking to treat cases not well within the physician's experience and understanding.

* Read before the Staff of St. Luke Hospital, Pasadena, California, November 16, 1944.

13. Failure to secure consent to operation and for autopsy.

14. Failure of the physician to keep abreast of developments in his profession.

15. Utilization of procedures of an experimental character.

16. Failure to employ x-ray and clinical laboratory facilities in diagnosis and in treatment.

17. Failure to exercise ordinary care in maintaining plant and equipment in a safe condition, and

18. Abandonment of the patient.

While there are some other contributing causes of malpractice which might be noted, every physician should at least bear these eighteen in mind and should protect himself accordingly. In any consideration of malpractice, because of their paramount importance, reference should be made to medical case records. It must never be forgotten that good records afford the physician his greatest protection against any malpractice claim.

ACCESSORY CAUSATIVE FACTORS

We should understand, too, that there are cases in which the criticism of a third party plays little or no part. These may be conveniently grouped as follows:

1. Those in which the doctrine or res ipsa loquitur ("the thing speaks for itself") is held to apply, as in cases of diathermy burn, sponge left in the tissues, etc.

2. Those in which it is held that the facts are within "common knowledge and observation," and hence the plaintiff is not required to present medical expert testimony in order to make his case.

This group is very similar to group 1, and may be illustrated: During a tonsillectomy the uvula and the anterior and posterior pillars were removed. The court said that it is a matter of common knowledge and observation that this is no part of a tonsillectomy.

3. Those based upon the failure of the physician to obtain the patient's consent to the procedure undertaken. No expert testimony is required in these cases.

4. Those based upon an invasion of right of privacy, the patient complaining of having been exposed to shame and humiliation. To illustrate: In a recent case a patient claims that something like a public parade passed through the delivery room while she was being delivered.

COMMENT

It should be noted that the cases in these several groups border on malpractice, or may be taken for actual instances of malpractice. They all, more or less, speak for themselves and do not require the critical remarks of a physician to mold them into actual claims. Moreover, physicians, by careful attention to the requirements of good practice can, in large measure, avoid claims based upon situations such as those illustrated in these four groups.

It is completely different in a great majority of malpractice claims. In at least 80 per cent of them the attending physician has possessed and exercised ordinary and average professional skill, care, diligence and judgment, in the diagnosis and treatment of the case. Despite all his care and attention, unsatisfactory results occur. The next physician coming on the case, basing his opinion on his findings and upon what the patient tells him, permits himself to be critical of his predecessor—another example of the distressing formula, viz: bad result, plus some physician's unethical criticism equals unjustified malpractice suit.

ON RELATION OF THE LEGAL PROFESSION

Physicians are inclined to blame attorneys for bringing these many unjustified actions. One frequently hears: "Why doesn't the Bar Association do something about it?" But let us be fair and put the blame where it belongs. No one can reasonably blame an attorney for bringing an action on behalf of a patient, when some physician condemns as unskillful or negligent the care which was rendered to that patient.

The great and growing weight of the influence of the Bar is undoubtedly on the side of eliminating unjust legal actions. To promote that influence in the field of medical malpractice it is important that attorneys, as a group, be brought to recognize the fact that the medical profession, in seeking freedom from unjust persecution, is not seeking to work injustice on any patient who may have a deserving claim against a physician. Furthermore it is of tremendous importance that all medical testimony be fair and uncolored. Medical expert testimony must be worthy of the confidence we seek to have the Bench, the Bar, and the public, place in it.

CONCERNING PHYSICIANS—ILLUSTRATIVE CASES

Criticism of another doctor may be in words—direct and forthright, as "Who butchered you?"; "they made a mess out of you,"; "you couldn't expect anything else from a doctor like that," or, indirect and inferential as "I would treat it differently"; "that would not be my way of doing it"; "I wonder why the doctor did that."—or criticism may be indicated by attitude or action, by a shrug, shaking the head, lifting the eyebrow.

Instances of unjust claims incited by improper criticism may be cited in great number.

As illustrative of large groups, a few cases are referred to.

Case 1.—A patient presented an ugly scar and a large ventral hernia. She gave a history of a recent appendectomy. The physician, without going further into the matter, declared that he had never seen a poorer piece of work. A malpractice claim against the original surgeon resulted.

The actual facts:—The patient had an appendectomy. The appendix had sloughed from the cecum. A large abscess had developed into which intestinal content was draining. After surgery the patient developed an acute postoperative alcoholic hallucinosis. The patient refused

to permit the original surgeon to do secondary surgery, although, because of her poor financial circumstances the surgeon offered to do this surgery gratuitously.

CASE 2.—On a dark night an automobilist was endeavoring to push his stalled car off the highway. Another car struck him, catching his legs between the two bumpers. The result: compound comminuted fractures of both bones of both legs just below the knees, with great soft tissue damage and massive hemorrhage. When this patient was admitted to the hospital he was in severe shock, and in a critical condition. His care, even from hind-sight point of view, was splendid. One month later, both legs being in casts, x-rays showing good position and alignment, the patient insisted on leaving the hospital. This he did against his physician's advice. The patient was given instructions in writing to return to the out-patient clinic for further observation and treatment.

The patient did not return to the original physician. He consulted another physician. The second physician never contacted the first physician, or asked to see the several x-ray films which had been made. He did remove and reapply the casts. Later when it became apparent that there was non-union of the fracture of one tibia, the second physician imputed the responsibility therefor to the unskilled and negligent care of the first physician. As the result, suit was filed.

CASE 3.—An employed young woman developed a skin eruption. The physician, to whom she was sent by her employer, made a diagnosis of neuro-dermatitis. Her treatment included the use of a quartz lamp, but no x-ray. The patient, dissatisfied with her progress, consulted another physician, here designated as physician No. 2. Physician No. 2 sent the patient to a dermatologist. This specialist also made a diagnosis of neuro-dermatitis, and further reported that there was no evidence of radiation injury. Following this, physician No. 2 made a report to an insurance carrier on behalf of the patient. In this report he stated that she had sustained a third degree x-ray burn. He also wrote a letter to the patient's attorney incorporating this same statement. Suit has been filed against the original physician.

CASE 4.—A young woman, pregnant for the first time, began to have bright red vaginal bleeding during the third trimester of her gestation. The bleeding was not accompanied by pain. A diagnosis was made of placenta praevia. X-ray disclosed twin pregnancy with double breech presentation. She was kept in bed most of the time for several weeks, and the bleeding was well controlled. During this period she was twice admitted to hospital when the bleeding became more threatening. The periods of hospitalization covered about two weeks. Two days after her second stay in the hospital the patient went into active labor and hemorrhage became progressively worse. A consultant was called in and it was decided to do a Caesarian section. A low segment type of Caesarian was done. The patient developed a severe post-partum infection. The treatment she received was excellent and, all things considered, the patient did very well.

The patient's family were distressed by all these difficulties and worried because of expense. About two weeks after the delivery, the patient was removed from the hospital and placed under the care of a second physician. She was transferred to a second hospital. This was done without the prior knowledge of the first physician.

Suit is now threatened against the first physician. In a case such as this, very little incitation is necessary. It is believed that the threat to sue is due to the attitude and the remarks of the second physician. Whether the matter goes on to actual suit apparently depends entirely on him. The second physician has now been placed in posession of all the facts of the case. He might have had the full facts at any time had he sought them. If now he indulges only in fair comment, there probably will be no suit.

IN CONCLUSION

If an economic recession follows our war prosperity, it must be apprehended that there may be a marked increase in the number of malpractice claims.

Since it is physicians who start malpractice cases, it is certain that there will be a sharp decrease in malpractice incidence when physicians, themselves, stop instigating unjust malpractice suits. Whenever a bad result case is presented to any physician, that physician must insist upon being put in possession of *all* of the facts of the case before he permits himself to condemn the professional care previously rendered to that patient.

6777 Hollywood Boulevard.

PREPAID MEDICAL SERVICE PLANNING*

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At the present time considerable attention is being devoted to Prepaid Medical Service Planning, which is reviewed in this article in terms of the patient, family physician, and legislator.

Certain principles of medical care as applied to distribution and cost are also evaluated in relation to our American Way of Life. Prepaid medical service planning appears to be necessary for the post-war era. What future course to follow in this all-absorbing phase of health preservation is left to the judgment of the reader.

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Introduction

THIS article has been prepared as a condensed review of what appears to be a realistic approach to prepaid medical service planning.

The various views expressed may perhaps be of interest to patients, employers, physicians, and legislators, whether on a local, state, or federal basis.

* From the Office of the Commissioner of Health, Department of Public Health, Rockford, Illinois.

† For ease in reference, queries have been given numbers by Editor of CALIFORNIA AND WESTERN MEDICINE.

I—Orientation†

1—What kind of medical care is wanted?
It is self-evident that every American wants the **best medical service possible.**

2—Is this attainable?
America is the one country that has the **essential facilities** for offering the best medical service possible.

3—Why is this true?
Because American ingenuity and foresight have seen fit through voluntary and legislative means to support that type of medical practice, which has resulted in a system of medical care **unequaled in any other country in the world.**

4—Is this a priceless heritage?
Experience has shown, and statistics verify the contention that (1) life expectancy, (2) freedom from illness, (3) avoidance of premature death in this country, is an American heritage **which perhaps needs to be zealously safeguarded.**

5—Is this true in other countries?
Investigation and study apparently reveal that these same conditions **do not prevail in other countries.**

* * *

II—Medical Leadership

6—What is the reason for this American leadership?
America has been willing to accept the premise that all features of medical service, in any method of medical practice, of necessity needs to be under the immediate guidance of the medical profession.

7—Is this basic?
Apparently, because no other individual, or groups of individuals, are educationally equipped and qualified to exercise impartially this guidance and supervision.

* * *

III—Patient Coöperation

8—Is this true in terms of patients seeking medical care?
Just a little thought suggests the wisdom of not permitting any third person, or organization, **to come between the patient and his physician** in any medical relation.

9—What about responsibility?
In all fairness, it perhaps can be conceded that responsibility for the character of medical service can be borne by the profession with "advantage to all concerned."

10—Do patients desire to choose their own doctor?
Patients, in order to get well, need to be granted full latitude in choosing a legally qualified doctor of medicine, who will serve them among all those qualified to practice, and who is willing to give such service.

11—How do patients want medical service administered?
The method of giving medical service needs to be a permament **confidential** matter between the patient and a "family physician" if that patient is to be satisfied, protected, and given hope for early recovery.

12—Is this essential?
In order to be successful, it is highly essential that this relation be the fundamental and dominating feature of any medical service plan.

IV—The Cost of Medical Service

13—What about the cost of medical service?
In whatever way the cost of medical service is distributed, it of necessity needs to be paid for by the patient **in accordance with his income status,** and in a manner that is mutually satisfactory between the patient and family physician.

14—What about "cash benefits"?
Medical service need not, and must have no connection, with any cash benefits.

15—Are medical costs excessive in America?
To be realistic on this point, **the answer is yes,** similar to other costs in business, manufacturing, building a home, and educating children.

16—What can be done about it?
As in other fields, plans and preparations are being formulated to meet these costs on a prepayment basis.

17—How can this be done?
Through **prepaid medical service planning,** as in other fields of post-war planning.

18—Is this being done?
Yes, the American public at long last has come to realize that prepayment plans for medical service are as basic as any other planning to meet unanticipated emergencies.

19—Can full coverage be obtained?
Like any other assurance against the unexpected, insurance coverage against unexpected medical emergencies can, because of actuarial experience, be obtained on a **partial coverage basis only.**

* * *

V—Regarding Medical Institutions

20—What about the operation of medical institutions?
To be successful, which is the desire of the American public, it is highly essential that the medical phases **of all institutions** involved in medical service be under professional medical guidance and supervision.

21—Does this include all phases of hospitalization?
It should be clearly understood that **hospital service** and **medical service** are two distinct entities, and each requires separate consideration.

22—What are "medical service" institutions?
Medical service institutions, whether they function under the name of a hospital or some other name, are but expansions of the equipment of the "family physician."

23—What is the basis for this contention?
The family physician is the only one whom **the laws of all nations** recognize as competent to use these institutions in the furnishing of adequate medical service.

* * *

VI—Evaluation of These Institutions

24—Who can determine the adequacy of such institutions?
The medical profession, because of its unique, ultra scientific basic training in human illness, **is particularly fitted** to determine the adequacy and character of medical service in institutions.

25—Upon what does the value of these institutions depend?
The value of all medical institutions depends primarily on their operation according to **accepted medical standards.**

* * *

VII—What About Doctors?

26—What about the "all inclusiveness" of medical service?
Medical service in any and all forms, of neces-

sity, need to include within it's scope, **all legally qualified doctors of medicine** of the locality covered by its operation, who wish to give service **under accepted standards** of operation. This is basic as in every other type of business.

27—What medical service restrictions are undesirable to American patients?

There should be no restrictions on (1) **treatment**, or (2) **prescribing**, not formulated and guided **by the medical profession.**

28—Why is this apparently true?

The quickest way to afford the American people with **inferior medical service**, so prevalent in all too many other countries, is to allow a third person, whether he represents an individual, corporate body, organization, or civic authority, to place restrictions on (1) medical treatment, or (2) prescribing, which today can gain headway unless the **stop signal of "caution"** is observed.

29—Is there proof of this contention?

Inability to carry out an accepted method of treatment, or failure to obtain an accepted medicine, vaccine, or serum for patients, because of lay adopted rules and regulations promulgated **without medical guidance** seriously handicaps a patient in getting well.

30—Is this very prevalent at the present time?

Fortunately American ingenuity has seen fit to leave most of these problems up to the present time to the judgment of the family physician.

VIII—Medical Service to the Needy?

31—What about medical service to the needy?

Medical service systems for the relief of low income classes need to be limited strictly to those below the "comfort level" standard of incomes.

32—In what way does this apply?

Those able to pay should not share medical service of institutions designed primarily for those unable to pay.

33—Should the public assist in this regard?

Those unable to pay must of necessity have public consideration, as is the custom in this country today.

34—What about the low income or "white collar" group?

This is where the individual employer and insurance carrier can coöperate in solving a "common welfare problem."

35—Why has this not been done before?

Like all other emergency expenses, we all have not seen the wisdom of planning for what is called a "rainy day."

36—Should this be a matter of compulsion?

This is the problem for consideration. Its solution **rests with the people**, not the medical profession. The doctors can be relied upon for sound advice and counsel in this matter.

IX—Organizing Plans For Prepaid Medical Service

37—Is it a simple task to organize prepaid medical care plans?

It is not an easy, simple task to organize prepayment plans for medical care that

(1) will be **actuarially sound,**

(2) will not divert an inordinate amount of the income to **administration,**

(3) **will gain and hold the confidence** of the American public,

(4) secure the **wholehearted coöperation of all physicians,** and thereby permit a wide freedom of choice,

(5) contain within itself the necessary professional machinery which will assure all patients that **high standards of medical service** will be maintained.

X—Various Plans

37—Is this the reason for the many different prepayment plans?

The very fact that there are numerous different prepayment plans for medical service in the United States is a glowing tribute to the individual initiative of the American public.

39—What else does this indicate?

That the various people from the various diversified sections of the country **desire and want to preserve** local control and local administration of home affairs.

XI—Government Supervision

40—Can this become a state or federal function?

Medical service, like any other professional or business function, can become the province of a state or federal unit.

41—Is this what the American Public wants?

This is the question now confronting the thousands of existing and future patients in need of medical care in this country, who perhaps should be made aware of the threat to our American system of medical practice.

XII—Who Will Decide?

42—What is the answer?

The answer rests solely and only with the desires and wishes of patients themselves, and not with the family physician.

43—Why is this true?

Because the family physician cannot legislate—he is only the servant of his patients. He can only advise.

44—What will the physician do in this matter?

He will abide by the wishes and desires of the patient, who must choose what type of medical service distribution is wanted in this country.

45—What is the basis of this contention?

The family physician, through training, obligation to his patients, and attention to the arduous task of rendering adequate medical service to the sick is too busy to undertake the task of deciding what type of medical service distribution the American public wants.

46—Does he know what medical service is wanted?

Yes, he is overly conscious of the fact that all patients desire and hope for the best medical service possible.

XIII—Which System Is The Best?

47—Is Medical Service under government supervision the best?

This is what the American public has to decide—not the family physician—because he has no control over the matter. This is an important point, that perhaps should not be forgotten.

48—Which would be the best for the doctor?

Statistics show that the family physician, by and large, takes less interest in legislative matters than any other professional man. His aim is to serve humanity according to the medical facilities placed in his hands for service.

49—Why is this?

Because the very nature of his professional calling requires an approach, understanding, and consideration of people, not found in any other profession; **people when sick require a highly specialized method of approach.**

50—Is the practice of medicine a public matter?

Ask any patient or doctor and it will soon be learned that the practice of medicine needs to be one of the most confidential matters between the one being treated and the physician of the patient's own choice.

51—Is this the way the public wants it?

This is a matter for the American public to decide.

* * *

XIV—Governmental Control

52—Can governmental agencies carry on this function successfully?

No one really knows at the present time. There are many advocates of the present system and some favor the government entering this important phase of American existence.

53—What about the government system in other countries?

Nearly every foreign country has one system or another of governmentally supervised medical service.

54—Are they successful?

This depends upon

(1) what is considered "successful,"

(2) from what source the information is obtained,

(3) what constitutes adequate medical service.

The sickness, premature death and baby death rates in other countries are, however, quite different from the **prevailing low rates** in this country.

55—Are there many advocates of this system?

From an economic standpoint, all Americans are by nature endowed with an innate desire to have any agency, no matter what its origin, assure adequate medical service on a prepayment plan basis, whether sponsored by voluntary or official agencies, providing the medical service rendered is of **high quality and administered in a kindly manner.** These latter conditions are of supreme importance.

56—The matter then appears to be very simple?

With one exception perhaps, each patient, no matter his financial status, wants the best medical care possible when sick or near the "door of death."

57—Is this basic?

We will let you, Mr. Reader, be the judge.

* * *

XV—Voluntary Prepayment Plans

58—How do voluntary prepayment plans operate?

There are many voluntary prepayment plans for medical service in this country at the present time.

59—How many kinds are there?

In general, it perhaps may be said that there are

(1) commercial,

(2) nonprofit,

(3) employer or organization subsidized plans, of prepaid medical service in this country.

60—How many people today are covered with these plans?

It has been reported that over twenty-three million people are covered with these plans.

61—Have they been used very long in this country?

The **commercial or insurance plans** have been available for years; the **nonprofit plans** are of more recent origin; and the **employer subsidized plans** have been in existence for a number of years.

62—Do they cover all types of medical service?

No two of these plans are alike:

(1) some are limited in their coverage,

(2) a few provide full coverage, and

(3) others are very selective as to benefits.

63—Why is this?

Because the actuarial experience involved in sickness coverage through the "group plan" method has not been fully worked out as yet. It is well, perhaps, to remember that prepaid plans for medical service, of necessity, need to be on a **partial basis only,** like all other protection against fire, auto collision, and floods, if the premium cost is to be kept at a low figure.

64—What is meant by "employer subsidized plans?"

Many employers are uniting with employees to solve a "mutual welfare problem" by paying: (1) part, (2) half, (3) in some cases the entire premium cost of these plans.

65—Is this a good policy?

Time will tell. So far it appears that this procedure is beneficial in solving a **mutual problem.**

* * *

Comments Concerning Illinois Plans

* * *

XVI—One Voluntary Plan (in Illinois)

66—Can one of the voluntary plans be described?

In one county in Illinois, the local medical profession has formulated a plan which for illustration will be described.

67—What is the cost of this plan?

The cost of this voluntary prepayment plan for medical services only is as follows:

$1.00 per month for a single man, or $12.00 a year

$1.25 per month for a single woman, or 15.00 a year

$3.00 per month for a man and wife and all children between 3 months and 18 years of age, or $36.00 a year. It is also of interest that these amounts are reduced by 10 per cent when paid on an annual basis, which reduces the above amounts to $10.80, $13.50 and $32.40 respectively.

68—Can anyone take out this insurance?

For actuarial reasons, it is sold on the basis of not less than ten policyholders per group. (Any one desiring to carry Accident and Health indemnity coverage, however, at a minimum of $1.00 extra per month, may obtain this plan on an individual basis.)

69—Why is this?

There is no magical way to pay for medical service coverage; the well must help pay for the sick; there is no other way to pay the bill.

* * *

XVII—Coverage (In Illinois)

70—What medical services are included in this plan?

A fee of $2.00 per call in the event of any disabling illness; (1) on the part of a single man or woman up to 65 years of age, (2) on the part of husband or wife up to 65 years of age, (3) any dependent between 3 months and 18 years,

(4) the fee is paid regardless of whether the call is made in a physician's office, in a hospital, or in a patient's home, (5) the first two calls per person are deducted which must be paid by the patient, (6) in the event of a surgical disability payment begins with the first call.

71—Does this mean that disabling illnesses are included?

Yes, disabling illnesses, with some few exceptions are included in the plan, after the first two visits to or by the family physician as previously stated.

72—Why are the first two calls not covered?

This no doubt can be done, but the premium cost, of necessity, would have to be raised. Therefore the first two doctor calls for the present are not included. The plan aims to provide an easy prepayment method of partially meeting the expense of prolonged illnesses.

73—What diseases and accidents are not covered?

Venereal diseases, mental diseases, and accidents or sicknesses covered by "workmen's compensation laws" are not covered.

74—Are physical examinations and diagnostic procedures included?

These procedures are not covered at present; they may be at a later date.

75—Are surgical operations and maternity covered in the plan?

Yes, these conditions are covered, and although the maternity fee is only $30.00 for the present, this may be raised at a later date.

76—What about the total amount of insurance paid?

(1) The total amount paid for any one illness for a single person or any one member of a family is up to $250 in any one year, (2) the total for all children is up to $500 in any one year, (3) the total for husband and wife is up to $500 in any one year, (4) in lieu of the $2.00 per call, the patient may elect to take a flat surgical fee as enumerated in the plan.

77—To whom is this money paid?

To the patient, which aids materially in meeting prolonged emergency medical costs. The patient pays the doctor. It is not intended that this plan shall cover the entire bill of the doctor.

78—Does the plan cover hospital expenses?

Not in Winnebago County, because this is covered by a "Blue Cross" prepaid hospitalization plan.

* * *

XVIII—Combined Medical Service and Hospitalization Cost (In Illinois)

79—In simple terms, then, what is the total medical and hospitalization cost?

(1) For a single man $1.00 plus hospitalization at 65c, or $1.65 times 12 months equals $19.80 per year, (2) for a single woman $1.25 plus hospitalization at 65c, or $1.90 times 12 months equals $22.80 per year, (3) for a husband, wife and children $3.00 plus hospitalization at $1.30, or $4.30 times 12 months equals $51.60 per year per family. See previous statement on the 10 per cent reduction when the medical care phase of this plan is paid annually, which reduces the above amounts to $18.60, $21.30 and $47.00 respectively.

80—Are the two plans described sold together?

No, the two plans are sold separately because they are handled by two different organizations. At a later date the Northern Illinois "Blue Cross" hospitalization organization may sell both these plans on a group basis. This, however, requires a change in the present state law (of Illinois), which no doubt will be done this year.

81—Are these premiums excessive?

Under the contemplated government compulsory plan, the premium is to be 3 per cent on all incomes up to $3,000; which, if a person earns $2.000, would equal $60.00 per year, so it can be seen that the plans described are much less as far as costs are concerned.

82—How can employers assist in this program?

In some communities, businessmen and industrialists have deemed it advisable to coöperate with employees by partially subsidizing the premium cost of this mutual welfare problem.

* * *

XIX—In Retrospect

83—1. An attempt has been made to evaluate prepaid medical service planning in the United States.

2. Due consideration has been given to the voluntary and compulsory saving aspects of this all-absorbing means of meeting emergency medical care expense.

3. That planning can assume either of these two courses is self-evident from data presented.

4. One plan recently inaugurated in Winnbago County, Illinois, covering both surgical and medical service, together with detail costs is presented outlining a more economical voluntary plan, which includes private insurance policies, and which permits anyone to choose his own physician.

5. This plan appears to be more satisfactory than the anticipated government plan, in which 3 per cent of all incomes up to $3,000 per year will be imposed and set aside to meet unanticipated surgical and sickness emergencies.

6. Many people prefer to have their own choice of physician.

7. Which of these two systems is the most desirable is left to the judgment of the reader.

City Hall Building.

"Of Mice, and Men and Women"

(Continued from Page 54)

SUMMARY

Our purpose has been to collate from diverse sources the positive findings regarding the association of estrogenic activity with the development of cancer of the female genital system. It would be a distortion of facts not to say that the positive findings cited represent a minor part of the incidence of the cancers discussed. Quantitative results as in animals cannot be expected in incidental human observations. However, the above cited data should be sufficient to overthrow complacency toward the evidence of animal experimentation with estrogens. It is hoped that these clues to the sequence and causality in the development of cancer in the female genital system will lead to more detailed clinical studies, and ultimately to a basic and better control of the malignant tumors of the breast and uterus.*

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San Francisco.

* Bibliography furnished on request. (U. C. Med. School.)

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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PHILIP K. GILMAN, M. D.....Council Chairman
JOHN W. CLINE, M. D..Chairman, Executive Committee
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OFFICIAL NOTICES

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION*

Minutes of the One Hundred Eighty-ninth (189th) Meeting of the Executive Committee of the California Medical Association

A meeting of members of the Executive Committee of the California Medical Association was held in the C.M.A. offices, 450 Sutter Building, San Francisco, on Sunday, January 21, 1945.

1. Roll Call:

Present: Drs. John W. Cline, Chairman; Lowell S. Goin, President; E. Vincent Askey, Speaker; Philip K. Gilman, Council Chairman; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; Councilor Lloyd E. Kindall; Executive Secretary John Hunton; Hartley F. Peart and Howard Hassard, Legal Counsels; Dr. T. Henshaw Kelly; Dr. A. E. Larsen; Mr. Ben Read; Mr. W. Glenn Ebersole and Mr. William Losh.

2. Purpose of Meeting:

Chairman Cline stated that the meeting had been called at the request of the Chairman of the Committee on Public Policy and Legislation, Dr. Dwight H. Murray, to consider the status of proposed health insurance bills that might be presented to the Fifty-sixth (56th) session of the Legislature, now in session in Sacramento.

From the best information obtainable, it was stated that four or more bills would probably be submitted, as follows: The Health Insurance Bill by the C.I.O. (Committee of Industrial Organization); a bill by Governor Earl Warren; several bills by Farm Bureau groups; a possible bill that had been drafted by the California Medical Association.

General discussion followed concerning the outlook on possible legislative acceptance of one or a composite of these various measures. Inclusions in the various bills, as regards medical practice, financial support, administrative procedures and related matters received discussion.

3. Report from Chairman of the C.M.A. Committee on Legislation:

Dr. Dwight Murray of Napa, chairman of the C.M.A. Committee on Public Policy and Legislation, submitted a report outlining his committee's reaction to the various measures that had been proposed.

The importance of proper education of members of the medical profession and of the public was stressed. General discussion followed on the suggestions submitted.

4. Request of Dr. Rodney Yoell to Appear Before the Committee:

Dr. Rodney Yoell of San Francisco, having requested opportunity to address the Committee, it was voted to extend this invitation. Dr. Yoell discussed briefly the background of several health insurance bills and spoke somewhat of conferences he had had with representa-

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

tives of Labor and with one of the major political parties. Dr. Yoell stated he was in favor of free choice of physician; of fees based upon service; and the right of private physicians and organizations to conduct health insurance under proper standards. utilizing the insurance principle, but maintaining individual initiative and the right of reward in proportion to merit. He stated he was anxious to coöperate with the California Medical Association in attaining these ends.

Full coverage, deductible for first visit, insurance and capitation system were referred to. Dr. Yoell also referred to his own experiences with the American President Steampship Lines, and felt that Labor was somewhat insistent that the working man would be willing to pay reasonable fees for professional services rendered, but did not wish to pay extra charges. He felt that State and local control were preferable to Federal control.

5. **Comment on Various Health Insurance Bills:**

General discussion followed, which was participated in by members present, with special reference on who would sponsor certain bills, the extent of support by various groups, and so on.

The importance of a proper educational campaign was stressed, and ways and means whereby these ends could be best attained were referred to by several speakers.

Concerning publicity, it was felt that in addition to general advisory assistance from the firm of Foote, Cone and Belding which had made the California Survey in November, 1944, (Interpretative Report of same was printed in California and Western Medicine for May, 1944, on page 241), it was desirable to employ a technical group of publicity experts to carry out the details of the educational campaign.

It was agreed that a special committee, consisting of the Chairman of the Committee on Public Policy and Legislation, Dr. Dwight H. Murray and Executive Secretary John Hunton, with advice from the C.M.A. Executive Committee, should carry on the general supervision concerning publicity and public relations. Executive Secretary Hunton to be the liaison representative in this work.

6. **1945 Annual Session:**

Chairman of the Committee on Scientific Work, Dr. Kress, called attention to the complications which had arisen in regard to an annual session meeting, with special reference to transportation and hotel accommodations. It was agreed to authorize the Committee on Scientific Work to permit papers to be read by title; that is, papers could be presented by C.M.A. members from counties other than Los Angeles, but it would not be necessary for them to be present in person to read the papers. Such papers could be read by title only, with right for possible publication in California and Western Medicine, or if desired, could be read in Section meetings for the authors by delegated members of the Los Angeles County Medical Association.

7. **Employment of Public Relations Counsel:**

On motion made and seconded, the Executive Committee voted to employ a public relations counsel to represent the Association on matters of health insurance legislation.

8. **Proposed California Medical Association Bill:**

"An act to establish a system of social insurance, consisting of unemployment insurance and sickness insurance, and to establish a system of employment officers for this state and make an appropriation therefor, and to establish a system encouraging the people of this state to become enrolled in non-profit medical, surgical or hospital prepayment plans," to be presented to the Legislature on behalf of the California Medical Association, was then discussed in detail by Legal Counsels Peart and Hassard. Changes were suggested for several sections and the same were incorporated.

It was agreed that the proposed C.M.A. Act as amended should be submitted to the Legislature at such time and under such sponsorship as might be deemed most desirable. (Note: This bill was later submitted to the California Legislature as Assembly Bill 1200. In current issue of California and Western Medicine, see page 65 (for text of bill), and page 91 (for analysis).

9. **Surcharge on California Industrial and Compensation Cases:**

Legal Counsel Peart reported concerning the 15 per cent surcharge that had been authorized by the California Industrial Accident Commission, and spoke at some length concerning future plans on ways and means of best obtaining these objectives.

10. **Sacramento Conference Concerning Sickness Insurance Legislation:**

After discussion, it was voted that a conference be held in Sacramento on Thursday, January 25, as per instructions in the resolutions adopted by the House of Delegates at its special session on January 6, 1945.

It was agreed that President Goin should preside at the meeting. The persons who were to be invited and the general program was also outlined in skeleton form. Association Secretary Kress was authorized to make the necessary arrangements for a dinner meeting to be held at the Sutter Club in Sacramento on Thursday evening, January 25.

11. **Advisory Group to C.M.A. Committee on Public Policy and Legislation:**

The attention of the Executive Committee was called to a suggestion that the Advisory Committee to the C.M.A. Committee on Public Policy and Legislation be enlarged. (Section 4 of Chapter 5 of the By-Laws provides for advisory groups consisting of from two to ten members.) The Chairman of the Committee stated that Dr. Wilson Stegeman of Santa Rosa, a member of the Sonoma County Medical Society, would be added to the Advisory group, and that consideration of additional members would be taken up later.

12. **Public Relations Program:**

Report was made that Mr. W. Glenn Ebersole had completed his tour of county medical societies. It was agreed that the Chairman of the Executive Committee should notify Mr. Ebersole that his services would be used in the present legislative campaign, at the close of which the next annual session will be held, and future plans outlined.

13. **Adjournment:**

There being no other business, upon motion made and seconded, it was voted to adjourn.

John W. Cline, M.D., *Chairman,*
George H. Kress, M.D., *Secretary.*

OFFICIAL NOTICES

PROPOSED AMENDMENT TO CONSTITUTION

(Presented at Los Angeles by Lowell S. Goin. For reference, see California and Western Medicine, for June, 1944, page 297.)

Re: Past President

Resolved, That the Constitution and By-Laws of the California Medical Association be amended as follows:

In Section 1 of Article VII delete the words "Past-President";

In Section 8 of Article VII delete the words "Past-President";

In Section 1 of Article X delete the words "Past-President";

In Section 2 of Article X delete the second paragraph reading as follows:

"At the expiration of his term of office the president shall become the past president and serve as such for a term of one year thereafter, or until his successor assumes office."

In Section 4, Article X delete the words "Past President":

* * *

PROPOSED AMENDMENT TO CONSTITUTION CONCERNING RETIRED MEMBERS

(Presented at Los Angeles meeting of the House of Delegates by C.M.A. Council. For reference, see CALIFORNIA AND WESTERN MEDICINE, for June, 1943, on page 349.)

Amend Article IV, Section 1(c) of the Constitution of California Medical Association:

The Section 1(c) of Article IV of the Constitution of the California Medical Association is hereby amended by adding, immediately after the first paragraph contained in said section 1(c), a full new paragraph:

If an application for retired membership is submitted by a competent medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1(c) of Article IV will therefore read:

(c) Retired Members:

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

Then follows the portion before read, the provision being made therein, Mr. Speaker, to make it possible for the Council to act upon these applications. Many of these applications are submitted in January and February of a succeeding year. Under the present By-Law, applications can be considered only when the applicant has active membership. In any calendar year, if dues are not paid on or before April 1st, active membership then ceases as of date of April 1st.

* * *

PROCEDURE CONCERNING AMENDMENTS TO C.M.A. CONSTITUTION

ARTICLE XV.—AMENDMENTS

Section 1.—Procedure to Amend Constitution

Any member of the House of Delegates at any meeting of any regular annual session thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the Secretary and shall thereafter be published at least twice in separate issues of the official journal of this Association prior to the next regular session of the House of Delegates.

At the said next regular session of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that annual session, and if two thirds of the Delegates present and voting vote in favor thereof, the same shall be adopted.

Letter to C.M.A. Members Concerning Health Insurance Bills Pending in Legislature

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, San Francisco (8)

January 30, 1945.

To the Members of the
California Medical Association:

Dear Doctors:

Health insurance legislation has become the Number One item in the California Legislature this year. Public interest in it has been whetted and you will no doubt be asked by many of your friends in regard to it. Your Legislators are now at home for the legislative recess and will be seeking your opinion on this important question.

To clarify the position of the California Medical Association, as determined at the House of Delegates meeting early in January, the following summary should be kept in mind:

1. The C.M.A. has voted that it cannot endorse any system of compulsory health insurance which has been presented to it to date.

2. The C.M.A. has suggested that aid and encouragement be given to voluntary health care plans.

3. The C.M.A. has taken the lead in bringing together the representatives of government, industry, labor, agriculture, dentistry, hospitals and allied groups in an effort to arrive at a "complete and comprehensive solution to the entire problem of health care in California." Any matter of such great importance to all the people—calling for 3 per cent in *new* payroll taxes—calls for the most mature deliberation, particularly in these war times.

Under these conditions, it should be borne in mind that the C.M.A. is definitely opposed to Assembly Bill 449 (introduced by the C.I.O.) and Assembly Bill 800 (introduced for Governor Warren) but is solidly in favor of Assembly Bill 1200, the C.M.A. bill *to encourage the voluntary system of health care.*

As soon as these bills can be adequately analyzed, you will be given full information on them. Meanwhile, this information may be of help to you in meeting your friends. Now, of all times, the medical profession must present a united front in the interests of the public health and its own future.

Fraternally yours,

(Signed) DWIGHT H. MURRAY, M.D., *Chairman,*
C.M.A. Committee on Public Policy and Legislation.

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Proposed Sickness Insurance Act, Submitted by the California Medical Association to 56th California Legislature, January 25, 1945

ASSEMBLY BILL **No. 1200**

INTRODUCED BY MESSRS. SAM L. COLLINS, FULLERTON; C. DON FIELD, GLENDALE; THOMAS HAROLD WERDELL, BAKERSFIELD; T. FENTON KNIGHT, LA CANADA; CHARLES W. STREAM, CHULA VISTA; THOMAS M. ERWIN, PUENTE; CLYDE A. WATSON, ORANGE; AND ALBERT I. STEWART, PASADENA.

January 25, 1945

REFERRED TO COMMITTEE ON PUBLIC HEALTH

An act to amend the title and Section 3 of, and to add Articles 11 to 14, inclusive, comprising Sections 151 to 209, inclusive, to the Unemployment Insurance Act, relating to a system of social sickness insurance, both within and as a supplement to the system of unemployment insurance, and relating to a system of encouragement of non-profit medical, surgical or hospital periodical payment plans.

The people of the State of California do enact as follows:

SECTION 1. The title of the act cited in the title hereof is hereby amended to read as follows: "An act to establish a system of social insurance, consisting of unemployment insurance and sickness insurance, and to establish a system of employment officers for this state and make an appropriation therefor, and to establish a system encouraging the people of this state to become enrolled in non-profit medical, surgical or hospital prepayment plans", approved June 25, 1935, as amended.

SECTION 2. Section 3 of the act cited in the title hereof is hereby amended to read as follows:

SEC. 3. This act shall be known and may be cited as the *Unemployment Social* Insurance Act.

SECTION 3. Articles 11 to 14, inclusive, comprising Sections 151 to 209, inclusive, are hereby added to the act cited in the title hereof, to read as follows:

Article 11. Public Policy Relating to Sickness.

SEC. 151. The provisions of Articles 11 to 14, inclusive, of this act establish and provide for a plan of sickness insurance integrated with the system of unemployment insurance, together with a plan for state aid and encouragement to those of its citizens who enroll in approved non-profit medical, surgical or hospital prepayment plans.

SEC. 152. As a guide to the interpretation and application of Articles 11 to 14, inclusive, of this act, the public policy of this state with respect to the distribution of the costs of medical care and the practice of medicine and surgery is declared as follows:

With respect to those people in the State of California whose incomes are not sufficiently high to meet without undue hardship the costs of serious illness or injury, and whose incomes are not sufficiently low to qualify for public aid and assistance in county hospitals and private charitable clinics, there is a definite problem with respect to the payment of the costs of medical care. As to these people, the problem is how to distribute such costs so that an undue burden does not fall on a few unfortunate individuals, and yet at the same time preserve those forces in the field of medicine and surgery that have resulted in the quality of medical care in this state being as high or higher than anywhere in the world. Those forces cannot be preserved and fostered by any state action regimenting and stifling the competitive spirit or an individual's desire to do a better job. State control over the practice of medicine inevitably injures the competitive spirit and thwarts the initiative of individual physicians, and thus in the long run is injurious to the public health and welfare. Particularly, at the present time, state control would be a catastrophe to the health and welfare of the people of this state, because with available physicians and surgeons reduced by one-third, due to war conditions, the unavoidable disruptions during a period of change to a new and unfamiliar system of practice, coupled with the increased demand for professional services for minor ailments which experience proves is inevitable, would necessarily cause a complete break-down of medical care in California. The chaos caused by such a breakdown would expose the people of this state to the risk of epidemics, increased deaths, and in general all of the terrible consequences of an absence of a sufficient number of physicians to care for greatly expanded demands of the population.

While it is thus apparent that the problem of distributing the costs of medical care cannot be solved by a complete system of state control over medical services,

it does not follow that the state is helpless to aid and assist those of its citizens who face undue hardships through the burdensome costs of serious and prolonged illness or injury. Such state aid and assistance may take several forms: it may include payment of cash benefits to wage earners to assist in the payment of hospitalization costs incurred while ill or injured through non-industrial causes; it may take the form of a credit against the tax imposed by Section 44 of this act, for those employees in this state who have made due provision for the costs of medical care by enrolling in approved non-profit medical, surgical or hospital prepayment plans; it may take the form of an authorization to employers to withhold from the pay of non-objecting employees sufficient sums to defray the monthly dues or subscription charges of approved non-profit medical, surgical or hospital prepayment plans. All of these approaches to the problems aid in mass distribution of medical costs and yet do not interfere with good medical practice. Neither do they add further tax burdens on the people or impossible physical burdens on already overworked physicians during time of war. Further, they give real assistance to the many voluntary prepayment plans which are now serving the health needs of hundreds of thousands of people in this state. With these encouragements and benefits from the state, it is within the means of all wage earners to budget, through small monthly payments, the major costs of illness or injury to themselves or their families.

It is the purpose of the following articles to adopt all of the foregoing measures, to the end that the people of this state may be both encouraged and assisted to make due provision for payment of the costs of medical care and hospitalization on a periodic budgeted basis. The following articles shall be liberally construed to effect their purposes.

Article 12. Approved Non-Profit Medical, Surgical or Hospital Prepayment Plans.

SEC. 160. The term "approved non-profit medical, surgical or hospital prepayment plans" means each and all of the following:

(a) Any non-profit corporation holding a certificate issued by the State Board of Medical Examiners, the State Board of Osteopathic Examiners, or the State Board of Dental Examiners, under Subdivision (4) of Section 593a of the Civil Code.

(b) Any non-profit corporation holding a certificate of authority issued by the Insurance Commissioner under Chapter 11A of Part 2, Division 2 of the Insurance Code.

(c) Any insurance company holding a certificate of authority from the Insurance Commissioner authorizing it to transact a disability insurance business in this state.

SEC. 161. The term "approved hospital prepayment plan" means any corporation qualifying under subdivisions (b) or (c) of Sec. 160.

SEC. 162. The term "approved medical and hospital prepayment plan" means any corporation qualifying under subdivision (a) of Sec. 160, provided that it actually defrays hospital as well as medical or surgical costs as an integral part of its operations.

SEC. 163. The term "approved medical prepayment plan" means any corporation qualifying under subdivision (a) of Sec. 160 as to contracts issued which do not include defrayment of hospital costs.

SEC. 164. With respect to all workers enrolled in and entitled to the benefits of any approved non-profit medical, surgical or hospital prepayment plan, the contributions required by Section 44 of this act shall be adjusted as follows:

(a) The contribution to the fund of each worker who is enrolled in an approved hospital prepayment plan shall be 17/20ths of 1 per cent of his wages paid by an employer with respect to employment, except that the rate of contributions required of any such worker shall not in any year exceed 50 per cent of the general rate required of employers.

(b) The contribution to the fund of each worker who is enrolled in an approved medical and hospital plan shall be 10/20ths of 1 per cent of his wages paid by an employer with respect to employment, except that the rate of contributions required of any such worker shall not in any year exceed 50 per cent of the general rate required of employers.

(c) The contribution to the fund of each worker who is enrolled in an approved medical prepayment plan shall be 13/20ths of 1 per cent of his wages paid by an employer with respect to employment; except that the rate of contributions required of any such worker shall not in any year exceed 50 per cent of the general rate required of employers.

SEC. 165. No worker shall be entitled to the reduced contributions provided in Sec. 164 of this article if enrolled in or a policy holder of any insurance company qualifying under Sec. 160(c) of this article, unless the contract or policy issued to such worker complies with Section 10176 of the Insurance Code and contains the provision required for hospital service contracts set forth in Subdivision (h) of Section 11512 of the Insurance Code. If the commission determines that any contract of policy by an insurance company does not comply with the requirements of this section, the contributions of each worker to whom any such contract or policy has been issued shall immediately be restored to the rate set forth in Section 44 of this act.

SEC. 166. For the purpose of determining the rate of contribution by a worker under this article, the commission shall examine the membership certificate, subscription agreements, policies or other contracts issued by all approved non-profit medical, surgical or hospital prepayment plans, and shall classify each of such contracts under the rate imposed by Sec. 164(a) or the rate imposed by Sec. 164(b) or the rate imposed by Sec. 164(c). In making such classification the commission shall be governed by the provisions of Secs. 160, 161 and 162 of this article. Each such approved non-profit medical, surgical or hospital prepayment plan shall, upon request of the commission, promptly submit to it specimens of all certificates, agreements, policies or contracts currently being issued.

SEC. 167. Each worker who is enrolled in an approved nonprofit medical, surgical or hospital prepayment plan shall so notify his employer, in duplicate, on a form prescribed by the commission, indicating thereon the rate of contribution under this act applicable to him. The employer shall retain one copy of such form and forward the other copy to the commission with the next succeeding payment of contributions to the commission under the provisions of this act. After receipt of such notification the employer shall thereafter withhold from such worker's wages the applicable amount as provided in this article, and shall continue to withhold such amounts as long as the worker remains enrolled in any such approved non-profit medical, surgical or hospital prepayment plan. With respect to any worker who ceases to be enrolled in any such plan his employer shall, immediately upon such termination, restore the wage deductions provided in Section 44 of this act.

SEC. 168. The commission may make and enforce such regulations as are necessary to carry out the provisions of this article. The commission may prescribe such forms and the manner and time of filing same with it, as in its judgment are necessary to administer the provisions of this article.

SEC. 169. This article and the rates of contributions by workers herein provided shall not become effective until January 1, 1946.

Article 13. Group Contracts for Benefit of Sick or Injured Employees.

SEC. 180. It shall be lawful for any employer to enter into a written contract with any approved non-profit medical, surgical or hospital prepayment plan for the purpose of furnishing to the employees of such employer, or to the employees and family dependents of such employer, medical or surgical services or hospital care contingent upon sickness or injury, and to collect or retain a portion of the wages of the employees for such purposes and to pay the same over to the approved non-profit medical, surgical or hospital prepayment plan.

SEC. 181. Any employee may reject the coverage of such contract at the time the contract is entered into or at the time of his employment, if entering employment after the date of such contract, by giving written notice to the employer of his desire so to do, or, having been under such a contract, by giving such notice thirty days in advance of its anniversary date. It shall be unlawful for any employer to retain any portion of the wages of any employee who has filed such notice of rejection, and neither such employee nor his family dependents shall be entitled to any of the benefits of such contract.

SEC. 182. No contract entered into pursuant to the provisions of this article shall be valid or effective between the employer and a non-profit medical, surgical or hospital prepayment plan for a period of more than two years; provided that any such contract may be renewed upon its expiration. It shall be unlawful for any employer, except as in this act provided, to collect or retain any part of the wages of any employee for medical, surgical or hospital care and attention, or to use or expend any part of the wages of any employee for medical, surgical or hospital care and attention, or to use or expend any part of the wages so collected or retained for such purposes.

SEC. 183. No deduction in excess of 25c per day shall be retained from the wages of any employee who works three days or less. Any employee who has contributed under a contract with an approved non-profit medical, surgical or hospital care plan for a full month, or any part thereof, and who leaves the employment in which

he was engaged at the time such contributions from wages were made, shall be entitled to a receipt from the employer showing the period and the purpose for which each contribution was made, and such employee shall be entitled to the protection and benefits of the contract under which said contribution was paid to the end of the period for which the employee's payment applied. In the event such employee shall enter the employ of another employer during the period for which such contribution was made and retained from his wages, and shall file the said receipt with such employer, no further deduction from his wages shall be made for the period stated in said receipt. Except as hereinabove provided, the sums to be collected and retained by the employer and paid over to an approved non-profit medical, surgical or hospital prepayment plan under the provisions of this article, shall be such as are fixed in the contract.

SEC. 184. The contracts of any approved non-profit medical, surgical or hospital prepayment plan shall not be deemed to apply to sicknesses or injuries for which compensation is payable under Division 4 of the Labor Code, or for which compensation or indemnification is payable under any state workmen's compensation or federal employer's liability act, and nothing contained in this article shall supersede or in any manner impair the benefits of any medical, surgical or hospital care to which an employee is or would be entitled under any of said workmen's compensation laws.

SEC. 185. Every contract entered into under the provisions of this article shall state in clear and well-defined terms the services and care to be provided and each such contract shall at all times be open to inspection by any employee for whose benefit it is made. It shall be the duty of the employer to post, and keep posted in conspicuous places about his plant, notices stating that such a contract has been entered into for the benefit of the employees, and is on file in the office of the employer.

SEC. 186. It shall be unlawful for any employer to retain, directly or indirectly, any part of the money collected or retain pursuant to the provisions of this article for his own use or benefit, but all sums collected by each employer, prior to delivery to the approved non-profit medical, surgical or hospital prepayment plan, shall be deemed trust funds and shall be placed and kept in separate accounts by each employer. Such funds shall in no event become a part of the assets of the employer. In the event the employer shall fail to place and keep said funds in separate accounts and pay them over to such approved non-profit medical, surgical or hospital prepayment plans within the time required in the contract, or in the event said funds become commingled with the funds of the employer and the employer becomes bankrupt or insolvent or if a receiver is appointed to operate the business of such employer, the funds herein described shall be entitled to the same preference as given to claims of the state under Section 46 of this act.

SEC. 187. It shall be unlawful for any approved non-profit medical, surgical or hospital prepayment plan to pay any fee or commission to any employer, employee or any third person, except duly appointed employees or agents of any such approved non-profit medical, surgical or hospital prepayment plan, for soliciting or securing contracts of the character described in this article; and it shall be unlawful for any employer, employee or any other person, except duly appointed employees or agents of approved non-profit medical, surgical or hospital prepayment plans, to accept, directly or indirectly, any fee or commission from any such approved non-profit medical, surgical or hospital prepayment plan, for soliciting or securing contracts of the character described in this article; and it shall be unlawful for any employer, employee or any other third person, except duly appointed employees or agents of approved non-profit medical, surgical or hospital prepayment plans, to accept, directly or indirectly, any fee or commission from any such approved non-profit medical, surgical or hospital prepayment plans or any other person for soliciting or securing any such contract.

SEC. 188. Each employer shall keep a true and accurate record of the number of employees to which any such contract applies, the amount of moneys collected or retained each month thereunder, and such other information as the commission may by regulation prescribe, and each employer shall, on such forms as the commission may prescribe, report to the commission at the same time that contributions required under this act are forwarded to the commission, the amount of money collected or retained from employees and the amounts paid over to an approved non-profit medical, surgical or hospital prepayment plan during the calendar quarter for which payment of contributions is being made.

SEC. 189. The contracts, books and records of all approved non-profit medical, surgical or hospital prepayment plans relating to contracts with employers under this article shall be open at all reasonable times to inspection by the commission or its agents.

Article 14. Sickness Benefits.

SEC. 200. "Sickness benefits" means money payments payable to an individual with respect to disability when accompanied by confinement in a hospital for an illness or injury for which such individual is not entitled to compensation under Division 4 of the Labor Code, and is not entitled to compensation or indemnity under any workmen's compensation or employer's liability law of any other state or of the federal government.

SEC. 201. An individual shall be eligible for sickness benefits if

(a) he is ill or injured and is confined in any approved hospital in this state, and

(b) such illness or injury did not arise out of and in the course of his employment, and

(c) his hospitalization costs are not defrayed in whole or in part by any approved non-profit medical, surgical or hospital prepayment plan, and

(d) he has notified the commission of his illness or injury and has made a claim for sickness benefits as required by the regulations, and

(e) he would have been entitled to unemployment benefits under Article 5 of this act if he had become unemployed at the time of his hospitalization, and

(f) he is under the care of a physician and surgeon licensed to practice medicine and surgery in this state, and

(g) he has been continuously hospitalized for a waiting period of four days.

SEC. 202. The maximum total amount of sickness benefits payable to an individual in any one benefit year shall be an amount equal to the maximum total amount of unemployment compensation benefits which would be payable to the individual with respect to such benefit year under the provisions of Article 5 of this act.

SEC. 203. The rate of sickness benefits shall be computed in the same manner and in the same amounts as is provided in Article 5 of this act for unemployment compensation benefits. If an individual is hospitalized for a fraction of a week, one-seventh of the applicable "weekly benefit amount" shall be paid for each day of hospital confinement.

SEC. 204. All sickness benefits shall be payable directly to the individual entitled to the same. The commission may, in its direction, require individuals to produce evidence of application of sickness benefits towards the payment of incurred hospitalization costs, but under no circumstances shall any sickness benefit payments be made direct to any hospital, nor shall the payment of sickness benefits be in any manner conditioned upon the doing of any act by any hospital other than certification of confinement.

SEC. 205. An eligible individual is entitled to both disability unemployment benefits and sickness benefits in the same benefit year. The payment of one does not exhaust his right to the other. Payment of sickness benefits shall immediately cease upon discharge of the individual from the hospital.

SEC. 206. A claimant shall give notice of his illness or injury and confinement in a hospital to the commission, and shall be certified and recertified by such hospital with respect thereto within the time and in accordance with the manner and form prescribed by the regulations of the commission.

SEC. 207. The provisions of Article 6 of this act and the rules and regulations thereunder shall apply to filing and making claims for sickness benefits and the determination and review thereof.

SEC. 208. Sickness benefits shall be paid through public employment offices or such other agency as the commission may by rule approve, in accordance with such regulation as the commission may prescribe.

SEC. 209. All the rights, privileges or immunities proffered by this article or by acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal this article at any time.

Analyses of C.M.A. and Other Sickness Insurance Bills

For analyses of Sickness Insurance Bills, see in this issue, under Item Sixty (LX), on pages 89-92.

CHAPTER II
COMPULSORY HEALTH INSURANCE BILLS PENDING IN 1945 CALIFORNIA LEGISLATURE (56TH SESSION)

ITEM I

Governor Warren Drafts State Health Insurance Plan

Sacramento, Dec. 29—(AP.)—Expressing the opinion that at present only the wealthy and extremely poor are receiving adequate medical attention, Governor Warren, on December 29, proposed that California pioneer a compulsory health insurance program to provide care for those of moderate income.

Frankly anticipating opposition to the plan when he presents it to the legislature next month, the Governor said he expects "a lot of people will be startled, but there is a great need for it and we shouldn't let fear keep us from trying to inaugurate it."

* * *

If California adopts compulsory health insurance it will be the first state in the union to do so, Warren said.

People, the Governor told his press conference, were startled when the workmen's compensation insurance, old age pension and unemployment insurance laws were enacted.

"But most people now realize these laws not only are humane but essential to both employees and industry, and no thinking person would want to abandon them," he declared.

* * *

"While all details have not been worked out for the program which the Governor claimed would "raise California health standards to a degree which would make us the happiest and most prosperous we have ever been," he outlined the plan generally as follows:

Financing—Both worker and employer would be subject equally to a payroll tax, possibly 1½ per cent, which would go into a State fund to finance doctor, hospital and certain types of dental bills for all contributing workers and members of their families.

* * *

Payments—a State agency, representative of workers, employers and doctors, would set up standards, determine eligibility and fix fees. A patient would have a free choice in selecting his doctor and doctors could refuse patients. If the doctor entered the system he could not accept an additional fee from a patient covered by the plan.

The Governor emphasized he is opposed to "State medicine" which he said is a plan where doctors are put on the public payroll and patients are assigned.—San Diego *Union,* December 30.

ITEM II

Hit 'n' Miss

Medical Security

Voluntary medical insurance through coöperative groups may head off the trend to compulsory nation-wide insurance—but by one means or another, the U. S. is going to have medical security, *Fortune* magazine forecasts in the current issue.

"The best medical care is bought by the rich and—in some large cities—obtained free by the poor," *Fortune* points out. "To get first-rate care the middle-income group must mortgage itself. According to the National Health survey of 1935-36, 90 per cent of the population of this country cannot pay for medical and hospital care adequate to its needs by the usual fee-for-service methods."

Fortune cites support for medical reform from doctors as well as from the public at large. A survey of doctors in the armed forces by the American Medical Association shows 53 per cent wanting to go into the group form of private practice; while the national Opinion Research center recently found 68 per cent of the public in favor of having the social security law cover payments for doctor and hospital care.

"Many medical authorities agree that the present structure of medicine embodies serious faults," *Fortune* continues. "There is insufficient supervision of practice; insufficient use of auxiliary personnel; insufficient consultation between general practitioners and specialists. Even in cities many physicians cannot get a hospital connection.

"Not that we know no better. As a matter of fact there is one device—group practice—that embodies remedies for almost all these deficiencies.

"For years wide public recognition has been accorded such institutions as the Mayo clinic where under a single roof, a large number of carefully supervised doctors aided by highly trained auxiliaries put at the patient's disposal a mastery of all medical techniques, based on the use of complex, varied and costly equipment. Patients pay no fee to doctors engaged in such group practice. They pay fixed charges to the clinic, which pays each doctor a salary.

"But how," *Fortune* asks, "can doctors who want to serve the mass of the population located between the poles of wealth and indigence count on enough paying patients to make group practice possible?

"In recent years there has developed an answer to this question: prepayment for medical care. There are today some 210 voluntary prepayment plans in the U. S. with a total coverage of about 20 million people, 3,600,000 of whom get other than hospital service. Few such plans are connected with group practice now, but it is largely because of their spread and the implied potential encouragement of group practice that U. S. medical structure and economics may be said to be in transition.

"Once doctors and hospitals are available, the foundation of a reorganized medical system might be a network of voluntary plans for medical insurance.

"Medical fees could be kept at least as stable as in the past without breaking any anti-trust laws. The net take of the profession could be enormously increased through increased consumption of medical care. Certainly that half of all U. S. doctors who earn less than $3,000 annually would benefit: salaries in group practice are higher at every age level than comparable private practice average net income. And $50,000-a-year Park Avenue doctors could continue sitting at bedsides on that avenue on the old fee-for-service basis."—J. L. Burton in Woodland *Democrat,* December 30, 1944.

ITEM III

Governor Warren Drafts Health Laws

Sacramento, Cal., Dec. 30.—(UP.)—Governor Earl Warren has announced he will submit to the California legislature meeting next month a plan of compulsory health insurance financed by a payroll tax on both employers and employees.

The Governor said the insurance plan would cover both contributors and their families and would provide for payment of costs of medical and hospital care. He said he believed that expenses for purchases of drugs and perhaps for basic dental care also should be included. . . .

The plan probably can be financed by a 1½ per cent payroll tax on both employees and employers, Warren said, although he emphasized that the rate cannot yet be estimated exactly.

Outlines Views

"I am not for State medicine," Warren said, "where doctors are put on the public payrolls and care is paid for from governmental funds. I don't believe in that system . . . I do want to spread the cost of medical care by compulsory contribution of workers and industry, both of whom would be beneficiaries."

He pointed out that there have been attempts to set up health insurance plans in California for 30 years, culminating in the establishment of the California Physicians' Service in 1938, but that they had not been completely successful because they do not cover enough persons. . . .

"I'm convinced," Warren said, "that the time has arrived when we must, in order to fill our obligations, have such a system. We have talked about the matter in California for years . . . But, we never have gone very far beyond the study stage and talk stage although we have known that adequate medical care and hospital service is beyond the reach of the average citizen.

"Everybody has said for years that service is available only to the wealthy and the indigent and there is considerable truth in the statement."

Citing figures of the State selective service system as showing a need for an improved health program, Warren said that of every 100 California men examined for induction into the armed services 38 have been rejected on account of physical or mental deficiencies.

In all, he said that 374,000 men between the ages of 18 and 36 have been found defective. If the figure were projected, he said, it means that about 1,500,000 California residents are below standard in health.

"I'm sure that there are many people who will be startled at the idea of compulsory health insurance," Warren said, "but there are always people startled at new things even when they have to be done."

The Governor said that it might be necessary for contributions to start some time before benefits can be inaugurated, or the State might guarantee the benefit fund during a trial period.

The coverage should be broader than present coverage of unemployment insurance, taking in self-employed and other groups, Warren said. He added that it might be wise at least at first to place a ceiling on the income level of persons covered in the plan.—Lloyd Lapham in El Centro *Post-Express,* December 31, 1944.

ITEM IV

Health Insurance Now Practical State Issue

Governor Warren has finally made general health insurance a practical issue in California, by the proposals which he is preparing to submit to the Legislature. He now invites public discussion on them, which is all to the good, provided it is informed, seeking the facts, and not political phrase-making, devising slogans to win a prejudged case. . . .

The Governor has stated the essentials so well that there is no need to devote this opening column on the subject to a detailed analysis of them. What I have learned about it in over 60 years is far too much for the few hundred words of a single newspaper column. That must wait for another occasion; perhaps several of them.

May I, therefore, for this time, begin with a strictly personal account of the origin of my own active interest in the subject, which has continued, increasingly, throughout most of a now already long lifetime?

I first became acquainted with the "Krankenkasse," when, as a very young student in Berlin, I saw it operate under the system originally established by Bismarck, who had then only just gone out of office. This system of health insurance, inadequate though it was, appeared so much in advance of anything of the sort we then had in America that I began commending it, at first orally and in letters to my medical friends in Germany and in America. I have kept up that advocacy through public and personal channels, almost continuously ever since.

Bismarck was smart. He knew when he had got what he wanted and had the sense to hold on to it. In 1866 he had thrown Austria out of the then loose group of Germanic commonwealths, preparatory to the coup of 1871, when, after the defeat of Napoleon III, he established a Federated Reich, with Prussia as its dominant State and no Metternich's Austria as even second.

Then he set up formally parliamentary systems, both national and state, with the elections for the lower houses so thoroughly gerrymandered as to prevent any effective opposition, and the appointive upper houses, in which all legislation must originate, virtually under the Chancellor's absolute veto. There is no room here to describe the method.

Nevertheless it was Bismarck who set up the system of social security, including health insurance, which finally became the model for the whole civilized world—last of all America, and not yet general health insurance even here.

Possibly one of Bismarck's motives was the good of the country. But the more Bismarckian one was to beat the Socialists to it, and to keep the people quiet—which largely it did.

It nearly stopped the third of the great German migrations to America, this one of workers and peasants seeking the higher wages of America and the free western land under the homestead act. American standards were higher than German, for those who succeeded in the competition, and some continued to come for these motives, until two wars shut them off. But these social security laws made life safer in Germany, and many Germans preferred that.

Ever since Theodore Roosevelt at least we have had movements for such social legislation here—all except general health insurance, which the Fishbein propaganda miscalled "State medicine." Now even organized medicine, under Warren's challenge in California, is considering whether the time has not come to reverse that attitude.

The war has revealed how large a part of the inductees were physically disqualified, many of whom had never had adequate medical care. They have had it and learned to value it in the armed services, and when they return they will be satisfied with nothing less. Neither will organized labor, nor the more advanced members of the medical profession.

Now comes Governor Warren, with a challenge that cannot be ignored. He has stated it so well that no more need be said here, until another time.

But may I return to the personal note on which I started? It is some satisfaction to have lived to see the probable early fruition of a crusade in which I have been engaged for 60 years.—Chester Rowell, in San Francisco *Chronicle,* January 4.

ITEM V

California Medical Association Tables Medical Care Plan for State Health Insurance Idea

January 6, 1945.—Intimation that the California legislature will be asked to make State unemployment insurance funds available to solve the problem of mass medical care was made on January 5 before the House of Delegates of the California Medical Association, at the Elks' Temple in Los Angeles.

An advocate of the plan for making medical care an adjunct of the unemployment fund spoke before the closed meeting of the medical delegates.

Following his description of the plan, the delegates voted to table all proposals for a statewide health insurance system that had been placed before them earlier.

The resolutions committee was then instructed to meet last night and draw up new proposals for submission before today's session of the delegates.

Advocates of making the health care facility part of the state unemployment system pointed out that it is now in operation with outstanding success in Rhode Island, allowing full medical care for non-industrial accidents and illnesses with hospitalization of 21 days.

A spokesman for the plan pointed out that the Federal Government now holds in trust $621,000 000 of the California Unemployment Insurance fund, and that actuarial equations show that this would be more than adequate to provide mass medical care in addition to unemployment insurance.

No increase in unemployment taxation of either the employee or employer would be necessary to finance the health plan, he said.

The physicians showed especial interest in figures indicating that mass medical care could be implemented at small administrative cost under the present state unemployment insurance governmental department, while the formation of either an adequate voluntary insurance plan or a separate State department would create a large burden of expense.

It was pointed out that under the suggested plan, the physicians would be paid their fees under an arrangement similar to the workman's compensation law, and that no governmental control of the medical profession is inherent in the proposal.

The proposal for extending the State insurance fund mass medical care was in line with a resolution adopted by the medical delegates at an earlier session of their three day meet.

The resolution stated that the association would not oppose compulsory health insurance providing the people of California wanted it and were willing to provide adequate funds for its administration.

Both C.I.O. and A.F.L. labor union representatives were present at open session of the convention.

The C.I.O. submitted a proposal through educational and legislative director Albee Slade and State secretary Mervyn Rathbone calling for a health plan financed by a 3 per cent payroll tax, split between employees and employers, and covering all persons and their families now covered by the State unemployment insurance act.

The C.I.O. plan would call for additional taxation revenue of $250,000,000 a year, would affect about 6,000,000 persons, including indigents, and under it doctors and patients would have complete freedom of choice.

Gene Boyd, A.F.L. representative at the meet, was asked to comment on the C.I.O. plan, but declared the A.F.L. is going to wait and see what recommendations on health insurance Governor Warren submits to the legislature before taking a stand on the C.I.O. proposals.

Boyd said the A.F.L. "recognizes the need of a comprehensive system of socialized medicine," and warned the medical delegates that doctors must take the initiative in evolving an adequate plan if they wish to avoid imposition of State controls not to their liking.—Los Angeles *Daily News,* January 6.

ITEM VI

California Medical Association Rejects Governor Warren's Plan

Alternative to Health Insurance Offered

Los Angeles, Jan. 6.—(UP.)—The California Medical Association turned down today Governor Warren's suggestion for compulsory health insurance financed by payroll taxes.

The association proposed, in its stead, cash indemnities for ill or injured workers through non-industrial causes, to be paid by increased California unemployment insurance act benefits.

The medical association's House of Delegates described compulsory insurance as a dangerous threat to the practice of medicine under present wartime conditions and said that the disruption springing from revolutionary changes would result in a "catastrophe for the people of the State."

Delegates offered as a solution to the State's health problem a program extending the benefits and facilities of two already existing services and calling for more intensive enforcement of preventive measures.

Their plan depends upon legislative action to tap the growing surplus of the unemployment compensation fund, now $622,000,000. Without increasing payroll taxes, they would allow cash indemnities in payment of hospitalization costs.

The association espoused the cause of the California Physicians' Service, which for five years has been offering a statewide, non-profit prepayment plan for families in lower income brackets, and called upon the State, management and labor to help the C.P.S. attain its objectives. —San Bernardino *Sun,* January 7.

ITEM VII

Roseville Doctor Opposes Health Insurance Bill

Editor of *The Bee*—Sir: Your editorial of January 2nd, commenting on the Governor's proposal for compulsory health insurance in California, advances the following arguments:

Premise: Thirty-eight per cent of the draft age men in California have been found to be defective, mentally or physically. This is a fact.

Premise II: If these "defective" men had received proper and adequate medical attention a significant percentage would not have been found "defective." This is also correct. But when you consider that approximately one-third of the rejections were made for the single reason that these men were considered "mentally unsuitable" for military service, your argument loses considerable weight.

Premise III: These men did not receive proper and adequate medical attention because they or their parents were unable to pay the cost thereof. This statement is only partially true. Many people in California would not accept proper medical care even if they were charged for it through taxes.

Your conclusion: A system of compulsory State health insurance could have prevented the rejection of 38 per cent of these California draftees. This assumption is absolutely contrary to all human experience. Systems of compulsory State health insurance have always caused a lowering of medical standards.

Under our present system of medical practice the people of this country have enjoyed the best physical health record of any nation on earth. As many other nations have had state health insurance for several years, even before this war, and as none of them can equal our health record, we would do well not to "kill the goose that laid the golden egg."

L. W. Empey, M. D.

Roseville.

—Sacramento *Bee,* January 11.

ITEM VIII

Labor Pushes Prospective California Health Care Plan

Whatever else 1945 brings, it is sure to bring workers of California, and consequently of the other 47 states, a lot closer to organized health care via social insurance.

The movement toward a system of genuinely social sickness insurance based on compulsory collection from wage earners and their employers flows from three main sources, in this order: (1) organized labor, (2) organized medicine—as represented by the leaders of the California Medical Association, (3) the state administration, headed by Gov. Earl Warren (R.), who has just nimbly leaped to put himself at the head of a movement that he sees is inevitable.

Warren will submit to the California legislature this month a plan for compulsory health insurance financed by a payroll tax on workers covered by unemployment insurance and on their employers. Warren is already garnering credit for this liberal step unprecedented in the annuals of the 48 states and his backing of a good bill will be fine. However, the parade had already formed largely by and around Union groups and it was on its way when he ran to the head of the line waving a drum-major's baton as if he had thought it up.

On Dec. 20 an historic letter went to doctors in this area from the office of Dr. Lowell S. Goin, clear-thinking president of the state medical association. It said in part: "Labor intends to introduce into the January session of the State legislature a bill providing for the establishment of compulsory health insurance in California. . . . " —The American *Aeronaut*, Los Angeles, January. 12.

ITEM IX

New Deal Hopes For Regulation

An if-you-don't-act-uncle-will attitude has of necessity made states increasingly vigilant about their rights as self-governing commonwealths.

It is this fear of Federal intrusion into fields historically reserved to the states or to private enterprise which has impelled Governor Warren to propose health insurance in California and request new legislation regulating other forms of insurance now in effect.

California physicians will do well to determine among themselves by what means they can assist Governor Warren in the formation of a health insurance program which will set a national standard and not make traditional practice of medicine obsolescent.

Certainly that offers more for them than obstruction leading to Federal action setting up another agency with the bureaucratic propensity for regimentation.

Washington bureaucrats may be sowing the seeds of their own destruction by their continued zeal for the regulation of the lives of all Americans. But while they're still riding high California legislators had better give close attention to scrutinizing the operation of fire and life insurance companies within this State.

President Roosevelt has declared that his administration is not sponsoring legislation for regulating insurance companies. It is the old story of where there is so much smoke there must be some fire.

Such a disavowal does not accord with the obvious fact that the vast money resources of the nation's insurance companies would come in handy for certain New Deal planners. . . . —Sacramento *Union*, January 12.

ITEM X

Selective Service Examinations Show Health Needs

January, of this year, saw the completion of more than 13,000,000 examinations of registrants for the armed forces. This unprecedented mass of medical data is now being subjected to statistical analyses, according to an article entitled "National Program for Physical Fitness," by Col. Leonard B. Rountree, chief, medical division, National Headquarters, Selective Service System, published in *The Journal of the American Medical Association*, July 22. Colonel Rountree states that a picture of the health needs of the nation has emerged as a by-product of the examinations. Some of the high points of the article follow:

In five registrations between October 16, 1940, and July 30, 1942, all males between 18 and 65 years of age were registered. Twenty-nine million were between the ages of 18 and 45, but only 22,000,000 men, between 18 and 37, were subject to induction. The Selective Service classified all men within the 18 to 45 year age range, and the medical division advised local boards as to physical requirements for acceptance into the fighting forces. In this program, some 33,000 doctors and 10 000 dentists have participated as examining physicians and dentists for local boards or as members of medical advisory boards. *All this service has been gratuitous.*

Results of all medical examinations have been recorded on special forms provided for this purpose, and copies of more than 13,000,000 of such forms are now filed in the Philadelphia branch of the Division of Research and Statistics of the Selective Service System. Of this number, approximately 4,000,000 are rejectees.

More than one-third of all rejections are for neuropsychiatric reasons.

The 4-F pool has grown at the rate of approximately 85,000 per month during the last year. Age distribution in this group as of March 1, 1944, showed 1,400,000 under 26; approximately 700,000, 26 to 30 years, and 1,400,000 between 30 and 38. Above 38, experience has shown that there are few who can qualify and serve satisfactorily.

A National Committee for Physical Fitness, created in 1943, has launched a program to help solve this great problem, but, Colonel Rountree states, vigorous medical leadership is essential to success.—San Francisco *Argonaut*, October 13, 1944.

ITEM XI

Dentists O. K. Health Levy

Favor Governor Warren's Proposal of Prepaid Medical Care

Dentists of California went on record on January 12 as favoring Governor Warren's proposal for a system of prepaid medical care through compulsory health insurance, insofar as dentistry is concerned, and pledged coöperation in working out such a program.

This was revealed in a statement issued by Dr. Harry H. Bleecker, president of the Southern California State Dental Association.

"It is the unanimous opinion of the members of the executive councils of the California State Dental Association and the Southern California State Dental Association, that their representatives be authorized to coöperate in formulating the dental aspects of any comprehensive program for health service in which dental services are to be included," said Dr. Bleecker.

"The councils came to this decision at a recent joint meeting held at the University Club in Los Angeles."

Two Year Study

Dr. Bleecker pointed out that the decision was not reached hastily, but resulted from extensive study over a two-year period by the Council on Dental Health.

"Proponents of compulsory health insurance recently asked for our attitude on the proposal by Governor Warren," he said.

"The decision reached at the meeting of the executive councils of both California Dental Associations is our answer." . . .

—Los Angeles *Examiner*, January 13.

ITEM XII

Federal Health Legislation Study Announced

Washington, January 15.—Chairman James E. Murray

(D., Mont.) of the Senate education and labor committee, announced today appointment of a permanent nine-man subcommittee to consider all proposed public health legislation.

"The high rejection rates of Selective Service, and the recently issued report of the subcommittee on wartime health and education, have both emphasized how vitally the national security is determined by the health and physical fitness of the people," Murray said. "It is hoped that this Congress will produce legislation which in a proper way may make available more and better health care to the American people."—San Francisco *News*, January 15.

ITEM XIII

Governor Warren Health Program

Sacramento, January 15.—Probably destined to become the most controversial bill presented to the 56th session of the State Legislature, Governor Warren's compulsory health insurance plan will be introduced simultaneously to the Assembly and Senate late this week.

In revealing features of his proposed measure, the Governor admitted that some ramifications of it have not been worked out and that their final status will be determined by the commission, appointed to administer the program, after it has passed through the trial and error stages.

Doctors Opposed

The only organized opposition so far developed has come from the California Medical Association, but some senators and assemblymen have expressed disapproval of the plan because of its enforced financing method—the withholding of taxes from wages and salaries.

The plan, to be financed by withholding taxes beginning next year, is expected to go into operation January 1, 1947, the Governor announced, declaring it would take a year to build a fund sufficient to maintain it.

The bill will be introduced by Sen. Byrl Salsman of Palo Alto, and Assemblyman Albert C. Wollenberg of San Francisco, Warren said.

Withhold From Pay

Roughly, the plan simply says that 1½ per cent of a wage earner's pay shall be withheld from his paycheck to cover medical care, a like amount to be assessed against his employer, and that during an illness he will be attended by a physician subscribing to the plan, and at a fee to be fixed by the controlling State commission.

The program will include certain types of dental work and oral surgery.

To prevent an inequity to those in the upper salary brackets, the Governor said that an arbitrary point probably will be set so that those earners pay the tax on possibly only $4,000 of their income.

Limit on Withholding

"It obviously would be unfair to tax the $10,000 earner on his entire salary, while the man earning a great deal less is entitled to the same medical service," Warren said.

"Although we have set no definite place to stop, I am in favor of limiting the assessment to $4,000 of his income."

The Governor also said that self-employers, agriculture workers, and others who do not come under the unemployment plan, can receive the State medical service by volunteer payment of the full 3 per cent tax.

Degree of Sickness

Warren said there will be a limit to just how sick the recipient can be. If his ailment develops into a lengthy hospital case, he will have to foot the bill after the illness has passed an arbitrary point. That point is yet to be settled, the Governor added.

According to the plan, there will be a set price for various classes of ailments and surgical operations and no deviation from the scale will be permitted under the law, he revealed.

Can Be No Juggling

In illustrating his point, Warren explained:

"If the price set for a tonsillectomy is $25, the law will not permit the patient to have the operation performed by a surgeon whose fee is $50, the patient paying the extra $25 out of his pocket.

"If the patient wants to pay for his own operation, then he will pay it all and take the physician of his choosing. Otherwise he will accept one of the State's subscribing doctors and have it done at the fixed fee."

"There will be no mixed service, with the State paying part of the bill and the patient for extra service," he emphasized.

Tax Begins in 1946

The bill calls for the withholding tax to begin in 1946 and operation of the service to start in 1947, the Governor said.

"If we get it started now, it will give us ample time to iron out any objectionable phases and have a firm policy fixed," he said.

The Governor said he would not want to see the service start while so many Californians are away at war, asserting that to do so might interfere with fair operation of the plan.

Use Old Services

Pointing out that there now are some volunteer medical services in the State which are common to his plan, the Governor said that where these existed a direct tie-up between them and the State service can be made.

Hypochondriacs and persons with chronic diseases accumulated through the years will be an enormous problem during the first year of the plan's operation, the Governor believes, but he added that after recipients realize it is a lifetime service this problem will adjust itself.

Warren said he did not believe industry will offer material objection to the plan.

Aid to Industry

"Most industries have a health program of some kind in which they bear part or all of the expense. Any organization composed of healthy, contented people will be more vigorous, efficient and thereby more productive, which industry thoroughly realizes, he said.

No details have been worked out as to status of newcomers to the State, Warren said, as compared to those who will have paid in on the program for a year before it becomes workable.

Quicker the Better

"We may have to set a prescribed time for paying into the plan before an insuree can benefit by it.

"But, on the other hand, the entire program is aimed at raising our health standards, and the quicker we help an ailing newcomer, maybe it will be better for all of us.

"There are bound to be some inequities, which can't be helped, but it will average up so that every family will get a break," he believes.

* * *

In a letter mailed to each senator and assemblyman over the signature of John Hunter, executive secretary, the California Medical Association opposes the program on many points.

Doctors Say Too Much

The association contends that the withholding tax features will amount to $40 per person per year, and to which wage earners will seriously object.

The organization also contends that such a bill has

no place in the present scheme of California's plans while "3,000 of our doctors and 800,000 of our citizens are in the armed forces."

It also objects to the compulsory phase, declaring the California Physicians' Service is a volunteer plan aiming at the same result and more could be achieved by furtherance of it.—James M. Kendrick in Sacramento *Union*, January 15.

ITEM XIV

Warren Lists Principles of Medical Plan

One Year Required to Establish Fund to Launch Program

Sacramento, Jan. 14. (AP)—*Governor Warren said today he hopes Californians can begin enjoying benefits of his recommended health insurance program by January 1, 1947.*

If the current legislature approves his plan of building a state fund to meet costs of medical, dental and hospital care, the Governor said all of 1946 would be required to accumulate sufficient money to start operations.

Principles Listed

Announcing that the measure will be introduced in each house by Senator Byrl Salsman of Palo Alto and Assemblyman Albert M. Wollenberg during the coming week, Warren said he and the legislators have agreed on the following principles:

1. A payroll contribution of 1½ per cent by both employer and employee with workers and their families eligible for benefits.
2. Inclusion in the system of all persons currently covered by unemployment insurance, but with the tax applying only on the first $4,000 of annual earnings.
3. Allowing persons not covered by unemployment insurance to enter the system on a voluntary basis.
4. Payment of doctors and dentists on a fee basis with fees varying for different types of service. The Governor said he proposes a so-called capitation system where doctors are assigned a definite number of patients and are paid on the basis of the number assigned.
5. Permitting continuation of existing voluntary industrial health insurance programs when they meet State standards, but requiring payroll deductions for the State fund and benefit payments to the private group on the basis of service rendered.
6. Complete freedom of choice between patient and doctor.
7. Doctors will not be allowed to make "side agreements" for extra fees and continue eligible for State payments on the theory service would deteriorate for those not paying extra.
8. No exemption from the tax should be granted on the ground a patient wishes to be treated by a doctor not participating in the system.

* * *

Warren said he is not in sympathy with objections that employers should not contribute to the fund on the ground it is up to the individual to care for his own health.

Outside of the humanitarian aspects involved, Warren said, most progressive industrial organizations which have installed health systems have found efficiency increases.

"There are innumerable people who go to work half sick or really sick because they can't afford to go to the doctor," Warren said. "Others go to work distressed about a sick wife or baby and are almost worthless on the job. They slow other workers down."

The Governor said he did not agree with the contention the State should delay action until the close of the war to determine the attitude of medical men in the armed service. Surveys show, he said, that one-third of the doctors in the service want some form of group medicine. He added he hopes service medical men will be back in private practice by 1947.

The Governor cautioned that the program would develop a number of "abuses" in its first year, but expressed satisfaction they could be eliminated as experience was gained.

One abuse, he declared, would be treatments demanded by persons with imaginary illnesses.

"Medical men tell me this will be an enormous problem and that nothing but experience in administration can give us the answer," he declared.—San Jose *Mercury Herald*, January 15.

ITEM XV

Governor Warren Cites California Health Blot

Sacramento, Jan. 11.—(UP.)—Compulsory health insurance in California would result in a State "not only happier but more prosperous than ever before," Gov. Earl Warren declared today.

Warren announced last week that he will sponsor legislation to establish the health insurance program.

He called attention to the fact that 374,100 California men between the ages of 19 and 36 were found to have physical or mental defects when examined by the Selective Service System. . . .

"The only way health insurance can be made to work is to distribute the cost of basic medical care among all who are subject to its benefits.

"At present, only the wealthy and the very poor have access to adequate medical care. The great middle class can't afford it. As a result, there is no question but what the health level of this State is far below what it should be."

Warren predicted that "a lot of people will be startled by the thought of compulsory health insurance, but we always have been startled by new things, even when we knew they were necessary."

He cited workman's compensation insurance, which he said "no thinking person would have us abandon now."

Unemployment insurance and old-age pensions experienced similar "growing pains," Warren added.—Los Angeles *Independent Review*, January 16.

ITEM XVI

Governor Warren's Health Bill

Putting it down on paper and making it into a practical law isn't proving so easy for Governor Warren in proposing a prepaid medical plan for the California people. The Governor and his aides have been wrestling with the legislative form of the plan ever since he proposed it in challenging tones to the legislature when it convened a week ago yesterday.

* * *

The Governor in that part of his address to the legislators raised his voice slightly, spoke with a chip on his shoulder. His tone said plainly that this proposal was a controversial one, it was being vigorously opposed by the medical profession, but he was making it his number one project for his first term of office and he intended to support it the full limit of his ability and exert in its behalf all his influence as the State's chief executive.

* * *

Money for the health program will be on a deduction basis for wage-earners, similar to the social security allotment plan. The medical take from the wage envelop will be 1½ per cent for each employee, the employer being required to put up a like sum. Those in the higher salary brackets will be taxed up to $4,000 of their gross

income. Beyond that they will be exempt. The health plan will apply to an entire family, including the wife and the children.

This writer has heard numerous legislators discuss the plan, arguing back and forth as to its feasibility. Some question was raised as to whether the public would approve a deduction that might prove hit or miss. The social security money goes to everyone. The health plan will provide medical care for the sick, while the healthier people may never benefit from it. If the money should be set up per family, and be returned if not used up by illness, the plan might be fairer to employee and employer, it is argued.

* * *

Illness is the worst financial setback suffered by most families in meeting their necessary living expenses. It is a setback because of the charges for hospital and medical service. Operations are expensive. Prolonged stays in hospitals are a drain on the family purse. Babies become luxuries because of the expense of bringing them into the world and seeing that they get medical treatment in the years they suffer from children's diseases. The support of the State health plan will come from people who know what it means to pay medical costs and who fear to be forced into debt again to meet such family obligations.

* * *

The Governor overcame one of the objections of the medical men when he proposed the plan not become effective for two years. The medical profession pointed out that many doctors are now in the armed services and those now practicing are overburdened with cases. A two-year postponement will help to get the fund started, will determine whether wartime conditions by 1947 will be such that the plan can become effective.

* * *

The success of the Governor's plan depends on its final form. If the legislature harmonizes with him in devising a practical system the proposal should meet with popular approval, because the medical need is great and the expense has become too much of a burden for most middle group families. The poor and the rich get care, while the rich and the better-salaried people help to defray the cost of the service given those who have no funds of their own. The health plan will spread the cost, make fees more uniform, provide medical attention for all and should promote the general public health. If it can be made to do these things by a workable law, then California will be taking the lead nationally in providing a great public benefit for the American people.—"Sacramento," by C. J. L., in Sacramento *Union*, January 16.

ITEM XVII

Warren Health Plan May Get "Kiss Off" of Politics, Pressure

Sacramento, Jan. 16.—Unless Governor Warren elects to make enactment of his compulsory health insurance proposal a test of his personal leadership, the proposal may be kissed off to some legislative interim committee for two years' more study, Republican majority leaders believe.

General Capitol feeling is that the program is "too strong medicine" for so-called conservative elements right now. If the Governor bears down, however, it is probable his own party would be reluctant to fight the program openly because of possible damage to Governor Warren's national prestige.

But opposition to the plan is strong beyond strictly political circles. Assemblymen and senators must heed some groups that want no part of compulsory health insurance. Any gubernatorial insistence on enactment now would be embarrassing to these members.

So they are already squirming. Some insist the issue needs more study. The Governor does not agree. He has pointed out emphatically that there has been plenty of time for "study" and that the time for action is here.

* * *

A number of counter measures, apparently designed to placate the Governor while making health insurance acceptable to opposing pressure groups, are in prospect.

The California Medical Association is expected to offer one such bill, according to Ben Read its legislative representative. Assemblyman Albert C. Wollenberg of San Francisco, and Senator Byrl R. Salsman, Palo Alto, will steer the Governor's bills in the respective houses

A pole away from the medical association stands the C.I.O—a pressure group quite as powerful as the medical fraternity—demanding legislation even more liberal than the Governor proposes.

Preliminary handling of the measure will fall to the Senate welfare and the Assembly public health committee, neither any playground for the bill.

So, to avert as much discord as possible at this session, referral to an interim committee is considered the ideal out by a lot of smart politicians from the red and green rooms.

But, even were that done, the question then would arise: "To which interim committee should it go?"—San Francisco *News*, January 16.

ITEM XVIII

Governor Warren's Health Plan

Governor Warren privately has little hopes that his compulsory health insurance plan will be enacted at this session of the State legislature, despite all the ballyhoo from his office.

The real lowdown on the situation is that the Governor decided to beat the C.I.O. and his Democratic rivals to the punch with his sponsorship of the legislation as a prelude to the 1946 gubernatorial campaign.

Prepaid medical care is the keystone in the arch of the C.I.O. legislative setup (they even have an initiative measure on it up their sleeve); many Democrats from labor districts are strongly for it, and now Warren states that it's his No. 1 legislative baby.

If it passes, all well and good: the Governor gets the credit. If it is defeated, well, he did his part and neither the C.I.O. nor the Democrats can blame him.

But plenty of opposition is developing, and the Republican legislators are definitely being put on the spot. Whether to go along with the Governor's program, which incidentally embraces every single C.I.O. objective, or to listen to the home folks is the problem confronting the lawmakers. Warren has tossed the ball to them and it is a decidedly hot political potato.

* * *

The doctors and the druggists and dentists, the insurance men and business men, big and little, are lining up their forces in every community of the State against the proposal. And when they really start putting the heat on their home town boys at Sacramento there's going to be a lot of them squirm and get the jitters.

Under cover, there is a growing revolt against any more payroll deductions. What with deductions for income tax, social insurance tax, private group insurance, union dues, war bonds, and what not, many legislators feel that the load on the wage-earner—and the employer—is tough enough. Compulsory health insurance might not be a bad idea in principle, but can it be afforded is the big economic question of the moment.

Governor Warren is willing to compromise, if necessary to put over his plan. But so far he hasn't been able to arouse much enthusiasm among his own party in the Legislature, and even Assemblyman Albert C. Wollen-

berg of San Francisco and Senator Byrl Salsman of Palo Alto, who will handle the legislation, are lukewarm on it—very lukewarm.

Don't bet any money on the Governor winning this one this year.—"Politicus" in San Francisco *Call-Bulletin*, January 16.

ITEM XIX

Health Insurance

We do not like the situation into which the health insurance proposition in the Legislature has fallen. The subject is complicated and very new to California. For this very reason we want to see it dealt with honestly and in the open. We will oppose the smothering of Governor Warren's bill, or any fast work on it in the committees.

The Legislature and the public need information on health insurance. There is a real demand for legislation to provide a system of insurance of medical care. This social advance is overdue here. But disinterested citizens want a sound system. We shall not get that without a full and honest discussion of all that is known of health insurance and of how the various plans have worked where they have been tried. We shall never get that by finagling either for or against the Governor's plan or for or against any other plan.

Those who, in the Legislature or out of it, work by devious methods to put over their own obsessions will find themselves the victims. One way or another, they will get the opposite of what they want. A dissatisfied public will lay the blame on them and in disgust perhaps force on the State some futile or disastrous scheme.

Health insurance is distinctly not a matter for antagonistic pressure groups, but for honest coöperation.—Editorial in San Francisco *Chronicle*, January 17.

ITEM XX

Sidney Hillman Says P.A.C. Is to Be Prepared

Oakland, Jan. 13.—(AP.)—Sidney Hillman told a conference of the California Congress of Industrial Organizations Council and State Political Action Committee the immediate job of the National Citizens Political Action Committee must be to organize for the 1946 congressional elections and for support of elements seeking world coöperation.

Earlier in an interview in San Francisco the national P.A.C. director said the organization plans to enter into the 1946 congressional campaigns in the same way it participated in the 1944 general election. . . .

Hillman, recently returned from a labor conference in England, said: "Large sections of Europeans believe that the entry of American labor into politics in a positive way means better hope for international coöperation."

The P.A.C.-C.I.O. conference advocated support of Governor Warren's compulsory health insurance bill; immediate enactment of a State fair employment practices act; improved old age pensions, better veterans benefits; more child care centers and reduction in voting age to 18.—Sacramento *Bee*, January 13.

ITEM XXI

Assembly Gets Health Bills

Sacramento, Jan. 18.—(AP.)—A half-dozen health insurance bills, some of them counter-measures to Governor Warren's prepaid medical plan, others merely modifying certain sections of his proposal, were disclosed today.

* * *

Assemblyman Augustus F. Hawkins, of Los Angeles, speaking for a Democratci bloc of 14 or more members, announced support of Warren's compulsory health insurance measure in principle, reserving the right to differ as to details of financing and administration.

No opposition which will endanger enactment of some health insurance legislation at this session, will be offered, he said.

* * *

Two of the newly-announced bills will be authored by Senator George J. Hatfield (R, Merced County) on behalf of the California Farm Bureau Federation. These would create voluntary, rather than compulsory health services, but wou'd provide a centralized control over all organizations which provide medical care on a periodic basis.

* * *

A C.I.O. bill and one sponsored by the California Medical Association, were announced. The former would provide for the "per capita" plan whereby physicians would be paid a flat amount on the basis of the number of patients they care for, rather than on a fee schedule, fixing the payment for operations and other specific services rendered. . . .—Hollywood *Citizen-News*, January 18.

ITEM XXII

Labor Economist Favors Two Changes in Warren Health Plan

Belief that "Governor Warren is really sincere about his compulsory health proposal, and wants the plan to work," was expressed today by Miss Margaret Stein, medical economist with the Northern California Union Health Committee who returned this week from Washington, D. C. She conferred there with doctors at the National Conference of Physicians Forum to obtain California's part in the over-all health picture.

"Governor Warren's proposal in general is excellent. Certainly we need a compulsory health insurance bill," she said.

"However, there are two points at which labor disagrees with the present projected bill. One concerns control. Labor believes that instead of an executive director who is a medical man, power should be vested with a commission representing both consumer and professional interests. Labor, agriculture, the public at large, the dental profession, and full-time teaching research end of medicine should be represented on the board along with the California Medical Association.

"Labor also takes exception to certain proposals for method of payment to the general practitioner. The trouble with the 'fee for service' plan as proposed by the Governor is that the consumer must be sick before he calls a physician—if he calls one.

"We prefer the capitation plan which gives health assurance through stipulated payment to the doctor for each citizen who selects his services, and thus assures checkup before severe illness occurs."

Specialists' fees, Miss Stein believes, would be taken care of under a special services division of the health insurance fund.

The California Medical Association's counter-proposal that funds from the unemployment insurance fund be used for cash disability benefits instead of instituting compulsory health insurance, Miss Stein is opposed to, since "we need a plan to guarantee service as well."—San Francisco *News*, January 18.

ITEM XXIII

Press Release: California Medical Association

(COPY)

San Francisco, January 18.—California's doctors are ready to give Governor Warren any requested assistance in writing his proposed health insurance bill despite the fact that the doctors have officially gone on record as

being opposed to the compulsory system which the Governor has announced.

That statement was made here today by Dr. Philip K. Gilman, chairman of the Council and president-elect of the California Medical Association.

"The Governor has not requested the California Medical Association to give him any help on his proposed bill," Dr. Gilman said, "but the Association is ready and willing to supply any technical details which the Governor may request. Through our experience of the past six years with California Physicians' Service we have accumulated a mass of actuarial data which we will be glad to lay in the proper hands upon request. It is doubtful if material of such value could be assembled from any other source in the country.

"If the Governor wants this material, all he need do is ask for it. However, this does not mean that the California Medical Association is acting as co-sponsor for any plan which might be evolved from the use of such facts and figures as we may be able to furnish. The House of Delegates of the California Medical Association has gone on record officially as opposing any compulsory health insurance plan which has so far been presented to it, including the outline of Governor Warren's plan as announced in the press and as given directly by the Governor to the Council of the Association."

Dr. Gilman detailed some of the reasons why the medical association is against a compulsory health insurance plan at this time, laying particular stress on the manpower shortage and the impracticability of setting up such a system under wartime conditions.

"The California Medical Association went on record in 1938," he said, "as favoring a system of health insurance. That was when California Physicians' Service was organized. This service has only recently emerged from the statistical study period encountered at the outset and has gained the knowledge of how a widespread health insurance plan can be operated with satisfaction to both the patient and the doctor.

"If we now attempt to extend such practices to a compulsory health insurance system and saddle the doctors and the patients with a new set of regulations and further payroll deductions, we are facing an immediate breakdown of the entire system of medical care in California.

"In the first place, there is grave doubt that sufficient manpower could be found to staff the administrative offices necessary in a Statewide compulsory plan. In the second place—and this is where the doctors are directly concerned—there are certainly not enough doctors in California to handle the additional medical work which would be thrown upon their shoulders if such a plan were instituted.

"The doctors of California and of all other states are working at top speed today. The death rate among the physicians is climbing because of overwork, long hours and the attempt to care for all cases which really demand attention.

"Now the Federal government is talking about drafting nurses and thus cutting off one of the mainstays of the doctors' offices. The burden in doctors' offices is already too great and any compulsory health insurance plan which is added on the top of the present medical structure can only bring a collapse.

"The California Medical Association has offered an alternate solution for immediate adoption. It has suggested that workers who are out of employment because of illness be granted unemployment benefits from present unemployment funds. Such benefits would help to ease the burdens of loss of income and medical and hospital expenses for the employed person.

"At the same time, the California Medical Association has gone on record as recognizing that a problem exists in the distribution of medical care and has suggested that a joint committee of physicians, dentists, labor, management, government, agriculutre, hospitals and others be established immediately for the purpose of conferring on a complete and comprehensive plan to cover the entire problem of health service in California. Invitations to all groups concerned will be issued by the California Medical Association within the next few days for a joint meeting to be held, if possible, within the next two weeks."

ITEM XXIV

Health Measure Needed

There are three choices before the people of California in the matter of health insurance. They are:

1. To do nothing about it.

2. To find themselves faced with several pressure-group initiatives, in which one they would have no part in drafting might be established in State law.

3. To cause the Legislature in session to frame carefully with the help of experts, and pass, a sane and sound compulsory measure.

To adopt the first course is to invite No. 2. The issue of medical costs is one which has become more insistent in recent years. If it is intelligently attacked, we do not believe the medical profession will suffer economically from it, or that medical standards will be impaired. We do not believe in "State medicine," so-called, nor in undermining the individual physician or his professional standing and pride, nor in subtracting from the complete freedom of choice of the physician by the citizen or patient. We want no compulsion in this direction.

But neither do we believe that the doctor or others who merely seek to maintain the status quo is being realistic about the forces at work in the modern economic world.

The issue of health insurance exists on a national scale, but we think it can be more adequately handled by State law running to a geographically more conveneint and compact population. Therefore we don't think the people of California can longer afford to do nothing about health insurance. We don't think the people of California can risk the possibility of being handed a pressure-group initiative, and having to vote for it as an evil less than that of rejecting it, or less than that of some rival initiative. Such initiatives are likely to be inadequate, ineptly or meretriciously framed, and they seldom look to the whole public welfare.

So we believe the people should press the Legislature to pass a compulsory health insurance law. No better program is in sight than the one now advocated by Governor Warren, and none is so likely to look to the whole public welfare.

We do not mean the Legislature should be urged to rubber-stamp this program. There is sincere controversy over some methods to be employed in such legislation, particularly as to whether physicians shall be paid on a fee basis or a per capita basis. The question appears vital to some, but in any case we advocate careful study by the Legislature and by the committees. All sides and all points raised by the proposed legislation should be heard, and every aspect weighed. The impartial particularly should be heard, but not the impartial exclusively. Experts, such as there are, should be called in, and a thorough study made of situations where health insurance already is being tried out.

The Legislature should take its full time to mature the measure and permit public opinion to mature. No hurry. But if special, or dogmatic or reactionary interests seek to smother this legislation by committee burial or other legislative tricks, we believe legislators who

have California at heart should smoke them out and bring the matter to a test. One not only can't fool all the people all the time, but unless one is in a legislative body only for what there is in it, one shouldn't even try.—Editorial in San Francisco *Chronicle*, January 18.

ITEM XXV

California Health Bill

American Hospital Group Official Hits California Plan

Declaring that more analysis and thought should be given to the proposed State insurance plan of Governor Earl Warren, Rex Bixby, managing director of the American Hospital Association has offered the services of that organization to the people of California, in an open letter addressed to the Governor.

"We believe that your proposal that California go down the enticing but dangerous road to socialized medicine requires much more analysis and thought than has yet been given it," Bixby wrote to the Governor.

Bixby also declared in the letter that "the road to destruction down which the countries of Fascism and National Socialism traveled was made attractive by just such paternalistic 'don't worry anymore, the State will do it for you' signs as that which it is now proposed to put before the eyes of Californians."—Los Angeles *Herald and Express*, January 18.

ITEM XXVI

C.I.O. Sponsors Health Bill; Will Seek Vote of People at General Election If Not Passed By California Legislature

Sacramento, Jan. 19.—(AP.)—The California Council of the C.I.O. announced today it will seek a vote of the people at the general election in 1946 if the present Legislature fails to approve its compulsory health insurance program "or a similar bill."

Mervyn Rathborne, secretary-treasurer of the labor organization, declared the C.I.O. backed legislation will be introduced in the Assembly Monday by Assemblyman Vincent Thomas, San Pedro Democrat.

If the measure or one like it fails of passage, Rathborne said, the C.I.O. will join with other groups to sponsor an initiative.

The C.I.O. program, announced just before both houses adjourned for the weekend, attracted particular attention due to speculation over how it will compare with the final draft of Governor Warren's measure to be introduced next week.

* * *

Rathborne outlined provisions of the Thomas legislation as follows:

Persons Included—All persons eligible for unemployment insurance, all State, county and municipal employees, their spouses and dependent children under 18; recipients of State and public assistance. The Federal Government could include its employees and public assistance recipients if it desired. Procedures would be developed to include farmers, farm workers and self-employed persons now excluded from unemployment insurance benefits.

Financing—A 3 per cent payroll tax to which employer and employee would contribute equally on the first $5,000 of annual income.

When Operative—Tax collections to start July 1 of this year. Benefit payments to start July 1, 1946.

Guaranteed Services—"All necessary medical care for each illness or injury" and not less than 21 days hospitalization for each illness when necessary, plus x-rays and other laboratory services. Oral surgery to be performed by a dentist or physician.

Administration—General policy fixed by a commission appointed by the Governor and consisting of representatives of employers, organized labor, farmers and the medical profession. The Governor would appoint a layman as executive director on nomination by the commission. "A highly qualified physician would be medical director with complete authority in all matters strictly professional in nature."

Patient Relations—Doctors would be paid a stated sum per patient per year. Individuals would have a choice of doctors and doctors could reject patients. Patients could change doctors each three months.

* * *

With the Senate voting to end the first half of its session a week from today and reconvene on March 5, legislators hastened today to get their measures into final shape. . . .—San Jose *Mercury-Herald*, January 20.

ITEM XXVII

C.I.O. Council Comments on Its Health Bill

Sacramento, Jan. 19.—(UP.)—The executive board of the California C.I.O. Council today told the State legislature to pass a compulsory health insurance bill "or else."

Mervyn Rathbone, secretary-treasurer of the council, said a bill entitled "the people's health act" will demand attention in the assembly Monday, January 21. It is sponsored by Representative Vincent Thomas, D., San Pedro.

If the legislature fails to pass the act or a similar bill, the C.I.O. intends to spearhead a movement to get it on the 1946 ballot as an initiative measure, Rathbone said. . . .—Los Angeles *Daily News*, January 20.

ITEM XXVIII

C.I.O. to Offer Public Health Bill for State of California

Sacramento.—The first public health insurance bill in opposition to Governor Warren's forthcoming proposals will be offered to the Legislature Monday, the California C.I.O. Council announced on January 19.

Attached to the announcement was a statement that the executive board of the C.I.O. Council has served notice that if the Legislature doesn't pass the People's Health Act or a similar bill, the C.I.O. will join with other groups to try for enough signatures to put such a measure on the next general election ballot.

C.I.O. Bill

Much of the C.I.O. bill is substantially or entirely similar to Warren's. Principal differences are:

Benefits in the way of medical care would begin July 1, 1946, instead of January 1, 1947.

Payroll contributions (1½ per cent by both employer and employee, as in the Warren bill) would be levied on a maximum salary of $5,000 instead of $4,000.

The fee schedule system of compensating doctors would apply only when "special medical benefits" are given. All other benefits, including hospitalization and laboratory, would be on a per capita basis.

A California Health Insurance Committee of nine appointed by the Governor would administer the act. The committee would be composed of two from the employer group, two from unions, two from the medical profession, two from agriculture and one from the general public. The majority of employees in the State, those not belonging to unions, would contribute most of the funds, but they would be without representation on the committee.

Assemblyman Vincent Thomas of San Pedro will introduce the measure. . . .—Chester G. Hanson, Los Angeles Times Representative at Sacramento, in Los Angeles *Times*, January 20.

ITEM XXIX

Health Bill to Exempt Religious Objectors

Christian Scientists, Others Would Not Be Compelled to Carry Insurance

Examiner Bureau, Sacramento, Jan. 20.—The compulsory health insurance bill to be introduced in the legislature Wednesday under sponsorship of the Administration will contain a provision exempting persons having religious scruples against participation in such a program, Governor Earl Warren disclosed today.

The Governor said he knew of no religious group which would be likely to object to participation, other than members of the Christian Science Church. The exemption, he explained, would be granted by the administrative agency, upon the filing of an affidavit by the objector.

"He would then be automatically exempted from the system," Warren said.

Religious Liberty

"We must include such a provision," the Governor added, "to protect religious liberty, which is a right guaranteed by the Constitution. I don't believe many people will make such an affidavit unless they actually have the scruples, but certainly, when people have certain religious beliefs, they should not be compelled, against those beliefs, to contribute to a cause opposed to them."

* * *

The Governor at his press conference asserted he believed the C.I.O. health insurance bill to be introduced Monday was "sound in principle," although he did not agree with the system of paying doctors proposed by the C.I.O. The Warren plan is based on the "fixed fee" system. The C.I.O. bill would pay a physician so much a month, a quarter, or a year for each patient under his care.

"There are many other details which differ," the Governor said. "But I am extremely hopeful that out of the two bills and any others that may be introduced, the Legislature will be able to write a real health insurance bill that will serve the needs of the public."

Osteopaths

At least 80 per cent of the osteopaths in the State will participate in the system, Warren said. Out of 2,000 osteopathic practitioners, about 1,600 are licensed as physicians and surgeons and will, therefore, be eligible under the proposed bill. . . . —R. W. Jimerson in San Francisco *Examiner*, January 21.

ITEM XXX

Medical Care Bills Will Go to Public Health Committee

Examiner Bureau, Sacramento, Jan. 22.—After much behind-the-scenes deliberation, members of the Warren administration and Assembly members favorable to compulsory health insurance have decided to refer all "prepaid medical care" bills to the committee on public health. . . .

* * *

The C.I.O. bill was introduced late today by Assemblyman Vincent Thomas of San Pedro and referred by Lyon without comment or objection to the health committee.

* * *

The public health committee headed by Fred F. Kraft (Republican) of San Diego, consists of 13 members, eight of whom are Democrats. The Democrats are generally regarded as friendly to a compulsory health insurance program, which means that the Democratic majority on the public health committee may be expected to give the bill a "do pass" recommendation. . . .—Los Angeles *Examiner*, January 23.

ITEM XXXI

Re: Report on Conference Between Governor Warren and Dr. Philip K. Gilman

(COPY)

San Francisco, January 24, 1945.

Mr. Larry Fanning,
Managing Editor,
San Francisco *Chronicle*,
San Francisco, California

Dear Mr. Fanning:

Today's *Chronicle* of Wednesday, January 24th, on the first page, contains a Sacramento dispatch from your political editor, Mr. Earl C. Behrens, in which appears a statement printed in bold face type, in which my name is mentioned.

The statement concerning my conference with Governor Warren reads thus: " . . . *Dr. Gilman's conference with Warren today was considered highly significant. It was indicative that there will be a split among the doctors over the action of their State Association.*"

Mr. Behrens' statement is in error. Mr. Behrens spoke to me as I left the conference with Governor Warren, and I told him I had seen Governor Warren at the Governor's request, but only as a private citizen, and not in any official capacity. The conference was arranged through State Health Director Halverson, who was informed that I could only see the Governor at this time as a citizen, and not as a representative of the California Medical Association.

The dispatch sent in by Mr. Behrens has placed me in an embarrassing position and I hope *The Chronicle* will make proper correction and also take steps to prevent a repetition of such errors. My conversation with Mr. Behrens should have left no doubt concerning the capacity in which I responded to Governor Warren's request for a conference.

Very truly yours,
(Signed) PHILIP K. GILMAN, M. D.

(Note. See also Item XLVI on Page 83.)

ITEM XXXII

Governor Warren Summarizes Conditions, Benefits of His Compulsory Medical Plan

Sacramento, Jan. 23—Governor Warren tonight summarized the highlights of his proposed compulsory health insurance bill as follows:

1. *Persons covered by the act.*

All private and public employees and their dependents, exceptions thereto being those classes not covered by the California Unemployment Insurance Act. These exceptions may come into the system on a voluntary basis, consent being required by both employer and employee.

2. *Contributions to be paid.*

Three per cent of salary or income up to $4,000, 1½ per cent paid by employer, 1½ per cent by employee; self-employed paying full 3 per cent. Entire collection to be handled by Employment Stabilization Commission along with administration of Unemployment Insurance Act.

3. *Benefits to be received.*

Prepaid medical care including specialist services such as surgery, etc., hospitalization where necessary, 21 days for each separate illness; drugs and other supplies during hospitalization. Dental services to be limited to extractions, surgery, treatment of infection, etc.

4. *Professional service.*

To be rendered by licensed physicians and surgeons (and osteopathic physicians and surgeons), and licensed dentists. Patient is insured free choice of doctor by fee system for compensation which contemplates payment to physician upon his rendering a proper statement to the

authority. No licensed physician or dentist may be denied registration except upon a hearing by a professional committee.

5. *Exceptions.*

Those who by religious belief do not desire the benefits from the act are exempt.

6. *Administration.*

Authority of 11 members. Three from employers; three from employees; three medical men, one of whom must have hospital management connection; one dentist, and the director of public health. Manager of system to be appointed by the Governor for a term of four years on recommendation of commission to operate under the direction of the authority.—San Francisco *Chronicle,* January 24.

ITEM XXXIII

California League of Women Voters Favors Health Insurance

State President Says No Specific Program Indorsed

Sacramento, Jan. 23. (AP)—Mrs. James G. Scarborough of Los Angeles, president of the California League of Women Voters, today announced that the league favors a compulsory health insurance program.

She said the league has not indorsed any particular program but favors a plan "based on principles and administrative practices which experience has proved to be sound."

Legislation Sought

The league is also supporting a Statewide mental hygiene plan, as well as "a program aimed at the prevention of mental illness," Mrs. Scarborough said.

Other legislation supported by the organization, which claims from 3 000 to 4,000 members in California, includes: . . . —Los Angeles *Times,* January 24, 1945.

ITEM XXXIV

Legislature Receives Governor's Health Insurance Bill

Governor Warren Will Press for Quick Passage; Full Details Outlined

Examiner Bureau, Sacramento, Jan. 23.—Governor Earl Warren tonight made public the major provisions of the "prepaid health service act" which will be introduced in the Legislature tomorrow and pressed for passage with all the force which the Warren administration can muster.

At the same time, Assemblyman Albert C. Wollenberg, who will handle the bill in the Lower House, declared strenuous opposition to proposals for creation of a special joint interim committee to investigate compulsory health insurance and then report back to the Legislature.

"Such a committee could stall health insurance legislation interminably, with the result that no bill of any sort on medical service could come out of this session," Wollenberg said. "That is the danger of the whole interim committee idea. We want health insurance acted upon at this session."

Points Outlined

The bill will be introduced by Wollenberg and others in the Assembly, with Senator Byrl Salsman and others sponsoring it in the Upper House.

Governor Warren tonight released without comment a digest covering the main points of the program. . . .

* * *

Although the bill will be introduced simultaneously in both houses, it is expected that the strategy will be to start action in the Assembly. It will be referred by Speaker Charles Lyon to the Public Health Committee, headed by Assemblyman Fred Kraft, San Diego Republican.

Kraft is also author of the resolution providing a joint interim committee to investigate health insurance, to which Wollenberg has announced opposition. Wollenberg said he had no objection, however, if the standing public health committees of both houses should get together during the February recess and collect "all the facts they want."—R. W. Jimerson in San Francisco *Examiner,* January 24.

ITEM XXXV

C.M.A. Invites Group Leaders to Discuss Health Plans

Statewide Conference Sponsored by California Medical Association

Prepaid health care plans now before the legislature will be discussed January 25 at a Sutter Club meeting in Sacramento of representatives of medicine, labor, industry, agriculture and government, Dr. Lowell S. Goin, president of the California Medical Association, announced yesterday.

Organizations who will send representatives to the meeting include the American Federation of Labor, C.I.O., Railroad Brotherhoods, Farm Bureau, State Grange, Associated Farmers, California State Chamber of Commerce, California Manufacturers' Association and the Merchants and Manufacturers' Association.

Governor Warren will attend, along with Lt. Gov. Frederick Houser, Attorney General Robert W. Kenny, Senator Jerrold L. Seawell of Roseville and Assemblymen Charles W. Lyon, Thomas A. Maloney, Sam L. Collins and Alfred W. Robertson.

Medical organizations invited to the session include the Association of California Hospitals, California State Dental Association, Southern California State Dental Association, California Pharmaceutical Association and the California Medical Association.

Proposed by the California Medical Association, the meeting was called to "start the ball rolling toward a sound, orderly and mutually acceptable plan for meeting the health needs of the people of California," Dr. Goin said.—San Francisco *Examiner,* January 24.

ITEM XXXVI

Basic Medical Services Outlined in Governor Warren's Health Bill

Examiner Bureau, Sacramento, Jan. 24.—Basic medical services provided under the prepaid medical care program sponsored by Governor Earl Warren, are enumerated in the bill introduced today in the California legislature.

Individuals under the proposed State system, the bill asserts, are entitled to "general practitioner services rendered by a physician or surgeon licensed in California, whenever such services are required by the standards of good medical practice for preventive, diagnostic, therapeutic or other medical treatment or care."

"These general services may be performed at the physician's office, or in a hospital or clinic," or anywhere else in California "in accordance with the standard of medical practice in the community in which the service is rendered."

In addition, the bill provides the following "basic services"—

Consultation and specialist services in addition to those of the general practitioner.

Laboratory and x-ray services.

Necessary hospitalization, excluding ambulance service, for not more than twenty-one days a year for each separate and distinct illness or injury.

Drugs, medicines and biologics, bandages, splints, and other supplies prescribed by the attending physician and

surgeon. Drugs other than preventive biologics are not included except when used in course of treatment in a hospital.

Certificate Required

Such general nursing service as is afforded by the hospital in which treatment is given, but not private or special nursing service.

Dental services "for the extraction of teeth, and for treatment of acute infections of the teeth, gums, alveolar processes and the bone adjacent thereto, or fractures of the jaw."

With the exception of these dental services and the "general practitioner" services first mentioned, all the other services "shall be furnished only upon the certificate of the general practitioner or specialist to whom the patient is referred." Presumably dental fillings and bridges would not be included.

Basic services are to be furnished for not more than one year for any one illness or injury, and will be provided for "tuberculosis and mental infirmities or disorders" only up to the time of diagnosis of such conditions.

Provision is made for amendment of these basic service provisions by a two-thirds vote of the eleven man authority which will administer the prepaid medical service system. The Governor may suspend the operation of any such rule or regulation in his own discretion. Except for modification of the basic services enumerated in the bill, the authority may adopt rules and regulations by mere majority vote of its members.

Increased Service

When the financial condition of the Health Service Fund warrants, the bill sanctions extension of service to provide one or more of the following: Increase of hospitalization period, additional drugs, additional medical or dental services, optometrical services.

Administration of the system will be in the hands of the California Health Service Authority, which will function with the Department of Public Health. One of the eleven members of the authority will be the State director of public health, and the Governor will appoint the other ten for four year terms. Salaries of the members will be $25 a day while attending meetings, plus their actual expenses. The Governor will designate the chairman.

The authority is to consist of three representatives of employers, including one employer of agricultural labor; three employee representatives, two from organized labor and one public employee; three licensed physicians, one of whom is experienced in hospital management, and one dentist.

Except for the collection of contributions from employers and employees, on the basis of 1½ per cent from each on salaries up to $4,000, all details will be administered by the authority. Collections will be handled by the Employment Stabilization Commission, which already collect unemployment insurance funds in California.

The authority's first duty will be to set up rules and regulations and fix fees to be paid for all health services furnished under the act. The authority need not make these charges uniform throughout the State.

Broad powers are given the authority in fields allied to health service. It may investigate hospitals, groups of registrants (banded together in various health services) employers and fraternal or charitable or other nonprofit health service organizations which may enter contractual relations with the State service.

The State treasury is pledged to assure the operation of the health service system until June, 1949. In a final section, the bill pledges the "faith and credit of the State," and adds:

"It is the intention and purpose of the legislature and Governor of this State that, in the event the funds herein provided are insufficient to accomplish this operation, such additional funds shall be provided as may be necessary, to the end that the health and safety of the people of the State be properly and adequately safeguarded."—San Francisco *Examiner*, January 25.

ITEM XXXVII

"U. S. and California Health Plans Need Not Conflict"

Sacramento, Jan. 25.—No conflict need arise between a State compulsory health insurance plan, and a Federal plan, should Congress set up such a program at the same time that the Legislature does so.

This is the opinion of Governor Warren's advisers, the understanding of the C.I.O., who introduced a health insurance bill of their own, and the advice of William Green, A.F.L. head, to state A.F.L. locals.

State officials are relying on the Wagner bill now before Congress, to provide for the negotiation of contracts with the surgeon general by any state for "agreements or coöperative working arrangements . . . to utilize State services and facilities and to pay fair, reasonable and equitable compensation for such services or facilities. . . ."

It is understood here that any political subdivision of a State, any "appropriate public agency" or even private agencies and institutions may make the same sort of contracts, under the Federal proposals. The Social Security Board has the power to approve the arrangements. But money paid under these circumstances would be reimbursed from the national "trust fund."

This possibility has been kept in mind by State officials during the bill-drafting process. They consider the right to contract would neatly mesh the two systems, and yet preserve for California greater local autonomy in managing the health insurance program.

* * *

The Sacramento dinner tonight (January 25) to which officials of the California Medical Association have invited proponents of compulsory health insurance does not represent the beginning of a concession, according to Dr. Chester L. Cooley, secretary of the San Francisco County Medical Society.

The meeting carries out a command of the doctors' House of Delegates "to meet with the leaders of other groups," he and other doctors say. But it is "no retrenchment."

Both the "compulsion" feature of proposed medical legislation, and control by a Government board are strongly objected to by the doctors. They argue it would make medicine the victim of politics "even without calling in State medicine." . . .

Meanwhile, Sacramento became a sudden attraction for the medical profession. Members of the Legislature introduced to their houses numerous medical men, visiting constituents. Requests for copies of Governor Warren's health bill mounted beyond 1,000 before it had ever been published.

The C.I.O. health insurance bill is AB No. 449. Any citizen may write the State Printer for one free copy.—San Francisco *News*, January 25.

ITEM XXXVIII

Health Service Bill Given to Legislature by Governor Warren

Hot Fight Seen on Warren Proposal

Examiner Bureau, Sacramento, Jan. 24.—Under the joint sponsorship of a group of both Republicans and Democrats, Governor Earl Warren's "Prepaid Health

Service" bill, setting up a system of compulsory health insurance in California, reached the State legislature today.

Signers of the bill introduced in the Lower House by Assemblyman Albert C. Wollenberg, Republican, San Francisco, included five Democrats and four Republicans. They were:

Democrats: Thomas Doyle, Los Angeles; Ralph M. Brown, Modesto; Francis Dunn, Jr., Oakland; Carl Fletcher, Long Beach, and Edward M. Gaffney, San Francisco. Republicans: Wollenberg; Walter J. Fourt, Ventura; John C. Lyons and Frank J. Waters, Los Angeles.

Difficulties Ahead

Senator Byrl Salsman, Republican of Palo Alto, introduced the bill in the Upper House. Coauthors were Senators H. E. Dillinger of Placerville and John F. Shelley of San Francisco.

The bill was referred to the senate committee on government efficiency and economy, which in the opinion of many observers means that compulsory health insurance will have a hard row to hoe. The eleven man committee is composed of veteran legislators, most of them conservative in makeup and with vast reserves of sales resistance. Chairman of the committee is Senator Ralph E. Swing, Republican of San Bernardino, with Harold Powers, Republican of Eagle Rock, vice chairman.

To Meet Governor

The assignment to the Governmental Efficiency Committee was made by the Senate Rules Committee, of which Salsman is a member. Although he had hoped for reference to the committee on social welfare, Salsman said the assignment ordered was "fair" and in line with precedent.

Swing immediately contacted Governor Warren and arranged for the committee to meet with the Governor late tomorrow, to learn Warren's desires with respect to handling of the measure.

The assembly measure was referred by Speaker Charles W. Lyon to the public health committee, headed by Fred F. Kraft, Republican of San Diego. Simultaneously Kraft dropped plans for a joint interim committee to study and "investigate" the whole subject of health insurance. . . .—R. W. Jimerson, San Francisco *Examiner*, January 25.

ITEM XXXIX

Keep Health Insurance Flexible

State Senator Byrl Salsman, in introducing Governor Warren's compulsory health insurance bill, said three alternatives are before the people of California:

(1) To enact the Governor's bill; (2) to have to vote later on an inflexible and possibly imperfect constitutional amendment; or (3) to have a Federal public health system imposed, with accompanying expansion of Washington bureaucracy.

We believe there is another that Mr. Salsman overlooked. That is passage of the Governor's bill so amended and confused as to make it entirely ineffective, thereby dooming the plan to failure. Opponents may attempt to kill it by that means.

Legislators who truly favor the principle of public health insurance should keep one aim uppermost. That is to make the measure as simple as possible with much of the administration left to the discretion of the commission. They should bear in mind that it is to be a great social experiment and that much can be learned only by experience. If they try to set up hard and fast rules in the law for all theoretical contingencies they will come out with an entirely unworkable system.

To be efficient in the formative period the plan must be flexible. When unanticipated conditions arise there must be leeway to meet them by prompt administrative action before they can bog down the whole structure. Gradually, as experience and practice disclose the weak spots they can be strengthened by rules and ultimately, perhaps, by remedial amendments of the law.

When the San Francisco Municipal Employees Health Plan first began operation it was threatened with total collapse by the demands made upon it. But regulations were adopted to meet each difficulty until a reasonable working basis was found. Since that time it has functioned with notable success.

The State plan will have to go through the same shaking down process. The Governor and those legislators he is depending upon to secure his bill's passage should make due allowance for this realistic circumstance.—Editorial in San Francisco *News*, January 25.

ITEM XL

California Medical Association Offers State Health Plan

Bill in Direct Opposition to Governor Warren's Proposal

Examiner Bureau, Sacramento, Jan. 25.—Flames of controversy over State health insurance sprang higher today with introduction of a bill sponsored by the California Medical Association in direct opposition to Governor Earl Warren's compulsory prepaid medical care plan, to be paid for by employer-employee contributions of 1½ per cent each.

* * *

The doctors' legislation provides for a reduction of an employee's contribution to unemployment taxes, now 1 per cent on the first $3,000 of annual income, by 15 per cent if he enrolls in a nonprofit hospital care plan, by 35 per cent if in a medical care plan and by 50 per cent if he enrolls in a plan combining both medical and hospital care.

* * *

No new taxes would be levied on the employee or employer.

Pointing out the unemployment insurance fund now holds more than $622,000,000, the medical association declared:

"The only way an employee can draw benefits under the present law is by being unemployed through being dismissed from employment. This bill would give employees a chance to draw benefits when they are hospitalized and are suffering from the dual burden of not drawing wages and carrying hospital costs simultaneously."

Assemblyman Sam L. Collins of Fullerton, G.O.P. floor leader, introduced the bill, which amends the Unemployment Insurance Act into a Social Insurance Act. Other developments were:

1. Assemblyman Jack Massion (Democrat), Los Angeles, said he, too, will introduce a measure that is sponsored "by the people of the State of California." It will provide insurance for everybody and in effect, it was understood, will be socialized medicine.

2. Administration supporters were opposing plans to require that the Assembly's standing public health committee, to which the Governor's bill has been referred, report to the Legislature by April 15 with recommendations on health insurance, contending such an unprecedented stipulation endangers chances of some sort of legislation at this session.

3. Preparing for public hearings during the February recess, the Assembly body sought a $5,000 appropriation and the Senate's governmental efficiency committee asked $2,000. Each apparently sought independent control over

the hearings, but they probably will meet jointly.

4. Governor Warren met late today with the upper chamber group, headed by Senator Ralph Swing (Republican), San Bernardino, to learn his wishes on procedure in handling his bill.

Despite administration opposition, however, the Assembly voted the April 15 deadline for a report by the public health committee. The fight against it was based on the argument that the committee could come in on April 15, contend it had not had sufficient time and delay reporting until after the Legislature adjourns.—Carl Greenberg in Los Angeles *Examiner*, January 26.

ITEM XLI

Legislature Gets State Medical Association's Health Measure

Sacramento, Jan. 25.—(AP.)—Governor Warren's compulsory health-insurance program ran into new competition on January 25 as the California Medical Association offered a rival measure to encourage voluntary participation in nonprofit medical and hospital plans.

While the medical association has openly opposed both the Warren and C.I.O.-sponsored legislation, legislators were surprised when the Association's bill was presented by Assemblyman Sam Collins of Fullerton, Republican floor leader in the lower house, and seven other Republicans.

* * *

As the Assembly concerned itself with health insurance and a flood of other measures were put in for consideration, the State Senate adopted a resolution calling upon Congress to make military training compulsory for the nation's youth when peace comes.

* * *

No Taxes Asked

The medical association plan not only dispenses with proposed new pay-roll taxes of 3 per cent shared equally by employer and employee as recommended by Warren and the C.I.O., but proposes to give unemployment insurance credits to those entering voluntary systems.

Employees enrolled in a hospital plan would get a 15 per cent unemployment insurance credit and those in a medical plan 35 per cent, with a 50 per cent credit if in both.

* * *

Governor Warren in announcing his compulsory program praised voluntary associations now in operation, but said they have failed to reach sufficient persons and a compulsory system is necessary to raise California health standards. . . .

Differ on Procedure

How the Legislature will proceed in hearing health insurance proposals remained in doubt. The Assembly approved a resolution calling for committees of the two houses to hold hearings during the February recess and report not later than April 15.

But Senator Ralph Swing, San Bernardino, who would head the Senate committee, said he and other Senators had called on Governor Warren and informed him they prefer to start hearings when the Legislature reconvenes. Swing said recess sessions would not develop information for the entire legislative membership.—Los Angeles *Times*, January 26.

ITEM XLII

Two More State Health Bills Introduced

"Voluntary" Insurance Measure, Backed by Medical Association, and Third Type System Offered

Examiner Bureau, Sacramento, Jan. 25.—Compulsory health insurance continued to hold the legislative spotlight today, as lawmakers speeded up the introduction of bills in an attempt to adjourn the January half of the 1945 regular session not later than Sunday night, January 28.

Developments included:

1. Assemblyman Sam L. Collins, Republican floor leader, and six others introduced the voluntary health insurance bill officially sponsored by the California Medical Association. Criticizing "State control of medicine," the bill has no compulsory features, but "establishes a system encouraging the people of this State to become enrolled in nonprofit medical, surgical or hospital prepayment plans" such as those now available to any employed group.

2. Another bill setting up a different type of State sponsored medical care program was offered by Assemblyman Jack Massion, Democrat, of Los Angeles.

3. Assembly and Senate groups were jockeying politely for advantage in arranging for committee hearings during the February constitutional recess. Indications were that the assembly standing committee on public health, and the Senate standing committee on governmental efficiency would hold a series of joint sessions.

4. Legislative bill room attaches reported demand for copies of the administration bill, printed as a rush order, is likely to break all records, indicating tremendous public interest in the subject.

5. The Senate committee, headed by Senator Ralph Swing, Republican, San Bernardino, met with Governor Warren late today to ascertain his wishes as to procedure in handling the bill.

6. Legislators, State officials, doctors, farm, labor, and industrial representatives met at the Sutter Club in Sacramento, on January 25, for an informal session at which views were exchanged on the subject of health insurance in general. The meeting was sponsored by Dr. Lowell S. Goin, president of the California Medical Association. . . .—R. W. Jimerson, in San Francisco *Examiner*, January 26.

ITEM XLIII

Doctors of California Outline Their New Health Plan

C.M.A. Substitute Introduced for Governor's Bill

Examiner Bureau, Sacramento, Jan. 25.—Assemblyman Sam L. Collins, Republican floor leader, today introduced the "voluntary" health insurance bill sponsored by the California Medical Association, as a substitute for the compulsory program advocated by Governor Earl Warren, and embodied in bills introduced on January 24.

The Collins bill is in the form of *amendments to the Unemployment Insurance Act, which is changed to the "Social Insurance Act,"* and enlarged to "establish a system encouraging the people of this State to become enrolled in nonprofit medical, surgical or hospital prepayment plans."

C.M.A. Bill Hits State Control

Declaring that "at the present time, State control of medicine would be a catastrophe to the health and welfare of the people of this State," the bill contains a detailed statement of "public policy relating to sickness." This statement would guide the administration and the courts in the event that the bill should become a law.

The C.M.A. bill concedes that there is a definite problem with respect to the cost of medical care, among the middle income groups. The problem, it is stated, is to distribute these costs "and yet at the same time preserve those forces in the field of medicine and surgery that have resulted in the quality of medical care in this State being as high or higher than anywhere in the world."

These forces will be injured by "any State action

regimenting and stifling the competitive spirit," the bill asserts. Particularly at present, due to war conditions and absence of a third of the total number of physicians and surgeons, the proposed change to a compulsory care plan would "necessarily cause a complete breakdown of medical care in California."

State Can Help

Without attempting to solve the problem by "a complete system of State control over medical services," the bill continues, "it does not follow that the State is helpless to aid and assist those in need of help."

* * *

The bill provides no new taxes on employer or employee, but, instead, provides a reduction in taxes for employees who protect their own health through joining voluntary prepayment medical or hospital plans. In effect, the Medical Association summary points out, this is an indirect State subsidy.

* * *

The system would operate within the present State unemployment tax structure. Employees now contribute 1 per cent of the first $3,000 of annual income. Under this bill, the contribution would be reduced 15 per cent on evidence that the employee was enrolled in a nonprofit hospital care plan meeting State standards.

* * *

If he enrolled in an approved medical care nonprofit plan, his contribution would be reduced 35 per cent. If enrolled in both a medical and hospital plan, the reduction would be 50 per cent.

* * *

Employers would be allowed to make pay roll deductions for payment of dues or premiums to these approved medcial and hospital prepayment plans. Exceptions would be made for employees who state their objections in writing.

* * *

Regular unemployment benefits would be paid, under the Collins bill, to employees who are hospitalized for illness and who are not covered by an approved nonprofit plan.

The C.M.A. bill says, of these provisions:

"These approaches to the problem aid in mass distribution of medical costs and yet do not intrefere with good medical practice."—San Francisco *Examiner,* January 26.

ITEM XLIV

California Medical Association: Digest of C.M.A. Bill (A.B. 1230)

Major Features

1. Provides for reduction in employee contributions to State unemployment taxes. Employee now contributes 1 per cent of first $3,000 of annual income. Under this bill the employee's contribution would be reduced by 15 per cent if he showed evidence of being enrolled in a nonprofit hospital care plan which met State standards of approval. If he is enrolled in an approved medical care nonprofit plan, his contribution would be reduced by 35 per cent. If enrolled in an approved medical and hospital care plan, his contribution would be reduced by 50 per cent.

2. Allows employers to make payroll deductions for all employees for payment of dues or premiums for approved hospital, medical or surgical prepayment plans. Exceptions under this rule would be made for employees who state in writing their objections to inclusion in such plans. This feature follows the election procedure of the National Labor Relations Act, providing that majority of employees may bind all employees in joining approved nonprofit plans.

3. Provides that regular unemployment benefits will be paid to employees who are hospitalized for illness and who are not covered for hospitalization by an approved nonprofit plan.

* * *

This bill will operate within the present tax structure. *No new taxes on employer or employee.* Instead, a reduction in taxes (indirect State subsidy) for employees who protect their own health through joining voluntary prepayment medical and/or hospital plans.

California is one of four states which impose a 1 per cent payroll tax on employees for unemployment purposes. Only way an employee can draw benefits under present law is by being unemployed through being dismissed from employment. This bill would give employees a chance to draw benefits when they are hospitalized and are suffering from dual burden of not drawing wages and carrying hospital costs simultaneously.

This bill is proposed as a means of fostering and extending the voluntary principle in health care—rather than the compulsory systems proposed by others.

ITEM XLV

Health Insurance As Proposed in 1933

We have come across an interesting reprint of a State document. It is entitled "Report of Senate Committee to Investigate the Advisability of a Health Insurance Act." dated April 19, 1933. Following is an excerpt:

"It is the duty of the Legislature to meet the human needs of today and tomorrow, to give the ordinary man and woman all the health protection that science and a progressive State can give. The right to pursue and obtain happiness is guaranteed to all by the fundamental law of the State. This right, by its very nature, includes the right to health protection and adequate care to restore and preserve health. . . .

We believe that there is a lesson in these words. In 1957 we would not like to dig out a similar futile committee report on health insurance requirements made in 1945.—Editorial in San Francisco *Chronicle,* January 26.

ITEM XLVI

Health Care Discussed by State Leaders at Dinner Sponsored by C.M.A.

Sacramento, Jan. 25.—Governor Warren's battle for the enactment of a pre-paid medical care in California under a compulsory health insurance system, produced major developments on January 24.

Tonight, about 30 leaders in government, agriculture, business, labor and the medical allied professions, met at a Sutter Club conference to discuss the health insurance question.

The dinner was called by the California Medical Association which today, through Assemblyman Sam L. Collins, Republican, Fullerton, and others introduced a bill proposing a voluntary rather than a compulsory health insurance system.

Governor Warren was unable to attend the dinner but was represented by one of his secretaries, Beach Veasy.

The majority of the speakers urged that the Legislature act carefully and slowly on health legislation.

Further meetings of the same group will be held from time to time.

* * *

Discussion of the general problem rather than any of the specific bills was the reason for meeting. The California Medical Association, through its House of Delegates, has gone on record in opposition to the Governor's program, or any compulsory system. . . .

* * *

The bill presented this afternoon by the California Medical Association declares it proposes "fostering and

extending the voluntary principle in health care—rather than the compulsory systems proposed by the Governor or the C.I.O. and others.

Digest of C.M.A. Bill

The doctors' bill would operate within the present tax structure, according to the release from the association.

A digest of the bill by the association's representatives states the following main provisions:

1. Provides for reduction in employee contributions to State unemployment taxes. Employee now contributes 1 per cent of first $3,000 of annual income. Under this bill employees' contribution would be reduced by 15 per cent if he showed evidence of being enrolled in a nonprofit hospital care plan which met State standards of approval. If he is enrolled in an approved medical care nonprofit plan, his contribution would be reduced by 35 per cent. If enrolled in an approved medical and hospital care plan, his contribution would be reduced 50 per cent.

2. Allows employers to make pay roll deductions for all employees for payment of dues or premiums for approved hospital, medical or surgical prepayment plans. Exceptions under this rule would be made for employees who state in writing their objections to inclusion in such plans. This feature follows the election procedure of the National Labor Relations Act, providing that majority of employees may bind all employees in joining approved nonprofit plans.

3. Provides that regular unemployment benefits will be paid to employees who are hospitalized for illness and who are not covered for hospitalization by an approved nonprofit plan.

* * *

As Private Citizen

The dinner meeting tonight was presided over by Dr. Goin, president of the California Medical Association. Dr. Gilman, president-elect, also was present.

Dr. Gilman conferred with Governor Warren Tuesday. He has asked that the writer make it clear that his meeting with the Governor was in his capacity as a private citizen.

Dr. Gilman also took umbrage at the writer's conclusion that his visit "was highly significant" and was "indicative that there will be a split among the doctors over the action of their State association." (Note. See Item XXXI on page 78.)

Because of other information, the writer believed the visit to have been significant not knowing at the time that Gilman had been appearing in his private capacity or that he had been invited to see the Governor by State Director of Public Health Halverson.

The writer had no desire to place Dr. Gilman in an embarrassing position but there can be no denying the fact there is a split among the doctors over health insurance. . . .

* * *

Tonight's dinner was the occasion for a general airing of views on the entire health problem.

Included among those invited to the dinner conference were Governor Warren, Lieutenant Governor Houser, Speaker Lyon of the Assembly, Speaker Pro Tem Thomas A. Maloney, Assemblyman Sam L. Collins, Assemblyman Alfred W. Robertson, Senator Jerrold L. Seawell; Von Elsworth, Farm Bureau Federation; George Schlmeyer, Grange; R. E. Badger, Associated Farmers; Pat Merrick, State Chamber of Commerce; John A. Pettis, California Manufacturers' Association; J. R. Chelew, Merchant and Manufacturers; Gilford Rolland, San Francisco Employers' Council; Mervyn Rathbone, State C.I.O.; C. J. Haggerty, A.F.L.; George F. Irvine, Harry See, Railroad Brotherhoods; A. A. Aita, president, Association of California Hospitals; R. R. Schoenfeld, Southern California Dental Association; Charles F. Gray, California State Dental Association; Jess D. Hardy, California Pharmaceutical Association; Drs. Lowell S. Goin, Los Angeles; John W. Cline, San Francisco; T. Henshaw Kelly, San Francisco; John Hunton, executive secretary, C.M.A.; Ben Read, C.M.A.; Hartley Peart, San Francisco, C.M.A., attorney; Dr. Howard Hassard, San Francisco; Dr. Wilton L. Halverson, State Public Health Director, and others.—Earl C. Behrens, in San Francisco *Chronicle*, January 26.

ITEM XLVII

G.O.P. Split Looms on Health Plan

Sacramento, Jan. 26.—A Republican legislative split over compulsory health insurance, advocated by Governor Warren, was clearly indicated today by both Senate and Assembly leaders.

Lieutenant Governor Frederick F. Houser, president of the Senate, and Speaker Charles W. Lyon of the Assembly, both urged caution before adoption of any plan.

Houser raised possible objection to the payroll deduction tax to finance the system, as urged in bills by the Governor and C.I.O.

Handicap Hinted

"In the case of manufacturers," he said. "This tax would probably be added to production costs and thus be a handicap in competition with outside industry."

Lyon declared he was "bewildered" by the maze of bills introduced on the subject in wartime.

"I am far from being convinced," he added, "that there is a real need and reason for prepaid medical care at this time."

Houser's and Lyon's views were made known at a forum meeting arranged by the California Medical Association at which business management and farmer representatives protested against "compulsion" or "regimentation" in any plan, while labor men voiced strong approval of some form of health service. Governor Warren was invited but did not attend.

Dr. Goin in Chair

Dr. Lowell Goin of Los Angeles, president of the Association, who presided, denied reports of any division in the organization on the issue, or that either a majority or minority of the members favored the idea.

"We have a vital problem to consider, and are studying all phases," he explained. "But a bad solution is worse than no solution at all."

Dr. John Cline of San Francisco told the gathering that compulsory health insurance was no panacea so far as the prevention of disease is concerned. He warned that lowered standards of medical care might result under such a system. . . .

* * *

The first half of the ession is due to end late on January 27. More than 2,000 bills have already been introduced, with about 1,500 more to come. . . . —James Adam, *Call-Bulletin* Political Writer in San Francisco *Call-Bulletin*, January 26.

ITEM XLVIII

Chiropractors Left Out of Warren Health Bill

Workers May Get Exemption on Pay Levy by Affidavit Stating Religious Reasons

Sacramento, Jan. 20.—Chiropractic doctors will not be included among those recognized as qualified to administer medical care under Gov. Warren's proposed health bill, it was disclosed on January 20 at the Governor's press conference.

In response to another of a series of rapid-fire ques-

tions, the Governor also said that followers of the Christian Science faith would not be required to participate in the program on the ground that religious freedom is a constitutional guarantee.

The employee who prefers chiropractic treatment for his illness cannot have such treatment paid out of the State health insurance fund to which he will be required to contribute, nor will chiropractic doctors be permitted to draw out of the fund.

Can Get Exemption

On the other hand, those employees who make an affidavit that they do not care to participate in the plan for religious reasons will be exempt from paying into the fund by way of the payroll deductions, the Governor said.

The questions and answers on this line came when the Governor was asked if he cared to comment on the compulsory health bill which the C.I.O. will have introduced in the Legislature next Monday.

Warren said he had not read the bill itself but from press reports on it he agreed with it "in principle." He was not indorsing the bill, he made it clear. His bill will differ from the union bill in many particulars. In one controversial particular it will agree.

Belong to Unions

Like the C.I.O. bill the Governor's bill will require that on the board which will administer the act the two representatives of the employees will have to belong to labor unions. In that respect it will be a "closed shop" bill as it is presented to the Legislature.

Asked why the working men and women of the State who do not belong to labor unions, constituting a majority of the workers, should not be represented on the commission, the Governor said he did not feel that stipulating that the employees' representatives on the commission should be union men was "freezing out" the nonunion men.

"Those interested in organizing themselves into unions are fairly representative of the workingman," Warren contended.

Wants Fee System

It was like the Chamber of Commerce being fairly representative of the employers' group, he noted, but failed to note that the bill did not say that the employers' representative has to belong to a chamber of commerce.

Warren said he could not agree with the C.I.O. bill on its proposal to handle the patients on the capitation system, that is, the doctor furnishes the service to the patient at so much money for a given time or a per capita basis. Warren will go for the fee system because, he said, so much of the medical service must be special service, such as surgery, dental and eye care, for which a specified fee must be charged.

The Governor announced his medical bill will be ready for presentation next Wednesday. The budget will be ready Monday. Recess is hoped for next Saturday or Sunday. . . .—Chester G. Hanson, *Times* Staff Representative in Los Angeles *Times*, January 26.

ITEM XLIX

California Medical Associates Invites Representatives of Government and Other Agencies to Conference in Sacramento

Government, labor, management, agriculture, dentistry, pharmacy, hospitals and others sat down with medicine at the Sutter Club, in Sacramento, on January 25, to discuss the broad aspects of medical care. A meeting of these groups, called by the C.M.A. in conformity with the House of Delegates resolution of January 6, 1945, drew a complete attendance of all groups invited and brought requests for invitations from many others. (See January California and Western Medicine, page 34.)

Participants in the meeting included representatives of the American Federation of Labor, the C.I.O., the Railroad Brotherhoods, California State Chamber of Commerce, Northern California Employers Council, Merchants & Manufacturers Association, California Manufacturers Association, California Farm Bureau Federation, California State Grange, Associated Farmers, Association of California Hospitals, California Pharmaceutical Association, California State Dental Association, Southern California State Dental Association, and the California Medical Association. Representing the State government were the Lieutenant Governor, the Speaker of the Assembly, the Assembly floor leader and one of the secretaries of Governor Warren.

Officers of the California Medical Association taking part in the meeting included Lowell S. Goin, C.M.A. president, John W. Cline, executive committee chairman, Dwight H. Murray, legislative chairman and several others. Doctor Goin presided.

Subject of discussion of the meeting was the broad question of health insurance, without any detailed discussion of specific health insurance bills which had just been introduced in the state Legislature. The discussion brought out the fact that the members of the Legislature present were not at all convinced of the necessity or advisability of passing compulsory health insurance legislation at this time, that the agricultural interests of the State are opposed to compulsion as a principle in health insurance and that the business interests of California are watching very carefully any proposals which might tend to increase taxes on California business.

Labor representatives presented varying views on the subject of compulsory health insurance legislation, with the C.I.O. the only labor group present which came out in favor of a compulsory system of medical care. Mr. Mervyn Rathbone, C.I.O. representative, spoke in favor of the compulsory health insurance bill sponsored by his organization, explaining that the C.I.O. did not believe that this bill represented the final answer to the problem and that it should be considered subject to proper amendments. He also expressed gratification at the gathering of the organizations represented at the meeting and asked that further meetings of this character be held.

It was agreed informally that further meetings should be held at the call of the C.M.A.

Keynote of the session was sounded by Doctor Goin, who said in his introductory remarks that the people of California are confronted with a problem in the distribution of adequate medical care, that all those groups invited to the meeting were vitally interested in the solution of this problem but that it was obvious that "a bad solution will be worse than no solution at all."

Further meetings of these organizations have not been scheduled at this writing but are expected to be called as soon as convenient for the various interested parties.

* * *

(Note. See in this series of reports, in re above. Item XXXV and Item XLIX.)

ITEM L

State Medical Care Bills

Assembly Group Plans Public Hearings on Warren's Health Insurance Measure

Sacramento, Jan. 26.—Statewide public hearings on Governor Warren's recommendation that California establish a system of compulsory health insurance will be held by the Assembly Public Health Committee during the constitutional recess of the Legislature.

The Legislature adjourns on January 27 until March 5

with the health insurance controversy the hottest issue before the lawmakers.

* * *

Hearing dates are as follows:
San Diego, February 13.
Los Angeles, February 15-16-17.
Fresno, February 28.
San Francisco, March 2-3.
Assemblyman Fred Kraft, San Diego, is chairman.

All Groups to Testify

Testimony will be taken from representatives of the California Medical Association, the C.I.O., A.F.L., Farm Bureau, Governor Warren, the dentists, chiropractors, Christian Scientists and all others interested.

* * *

Two more health insurance bills were introduced and plans were completed by the Assembly Public Health Commitee to hold public hearings on the health insurance question during the recess. Hearings will be held at San Francisco and Los Angeles.

While recognizing that his recommendation for the enactment of a compulsory health insurance act "is bound to cause a fight" in the Legislature, Governor Warren declared he was "very much encouraged because I feel the public is tremendously interested in health insurance."

Approval Cited

Warren said "any number of eminent doctors have expressed the belief I am sound in my approach to this problem and are hopeful a bill such as proposed will become operative."

* * *

Assemblyman Rosenthal, Los Angeles, proposed the identical bill which was before the Legislature in 1939. This would provide for compulsory insurance with the State contributing 1 per cent, the employer 1 per cent and the employee 1 per cent of his wages or salary. The capitation plan of paying doctors would be followed and disability benefits or hospital benefits would be provided at the choosing of the beneficiary of the system.

The State would contribute the entire cost of the health insurance system provided in the bill by Assemblyman Massion, Los Angeles. Massion's bill carries the capitation plan of paying doctors. It would be administered by a nine-member board, giving one membership to a chiropractor and one to an optometrist; two to physicians and one each to representatives of the dentists, pharmacists, hospital organizations and labor.

* * *

The Governor said he was disturbed over prospects that the Legislature might postpone action on health insurance by creating another interim committee. He said he has been informed by the Senate Governmental Efficiency Committee it would begin hearings on the several bills immediately upon reconvening of the Legislature. He said he thought the holding of public hearings such as proposed by the Assembly Public Health Committee was a good thing.

"Inasmuch as we have been studying this subject for 30 years and have had bills before the Legislature," said the Governor, "it seems to me we are now in the field of action and the people are entitled to a final determination by the Legislature at this session."

* * *

The Governor will leave for Washington Monday to appear February 5 before the Senate Foreign Relations Committee in opposition to the new water treaty with Mexico.

When he returns he said he would have before him exhaustive studies on the probable cost of the operation of his compulsory health insurance system. . . . —Earl C. Behrens, Political Editor of *The Chronicle,* in San Francisco *Chronicle,* January 27.

ITEM LI

Senator Shelley of San Francisco Proposes Sickness Unemployment Payments from Existing California Unemployment Fund

Senator William P. Rich, Yuba County, and others brought in the Governor's proposal for State regulation of private insurance companies and the fixing of premium rates.

Senator John F. Shelley, San Francisco, announced sponsorship of a measure to broaden the unemployment insurance program to permit grants of disability benefits. Under this plan, apparently similar to one now on the Rhode Island statute books, insured employees off the job because of sickness would get the same allowances to which they would be entitled if available for work but unemployed.—Sacramento *Bee,* January 27.

ITEM LII

Legislature Recess Began on January 27

The Returning State Lawmakers Face a Stormy Session Over 3,700 New Bills

Sacramento, Jan. 28.—California legislators face one of the most controversial sessions in the State's history when they reconvene here March 5 after the constitutional recess.

Among the 3,700-odd measures introduced in the Senate and the Assembly before the first half of the fifty-sixth session came to a close shortly before midnight on January 27 are proposals of far-reaching significance.

It required almost nine hours beyond the official 3 o'clock adjournment hour yesterday to complete the introduction and first reading of the titles of the 2,132 bills introduced in the Assembly and 1,253 bills in the Senate. More than 200 measures other than bills also were introduced at the session.

At the 1943 ssesion an even 3,000 bills were introduced in the first part of the legislative meeting.

Each lawmaker may present two more bills after the reconvening in March, so the total will go still higher....

Chief controversy will center around Governor Warren's compulsory health insurance system proposal. Then there will be plenty of fireworks over his other recommendations, which conservative Republicans consider too "liberal" and many Democrats do not want to support because Governor Warren, a Republican, has offered them.

There was but a handful of legislators left by the time the gavel was finally dropped in the Senate by Lieutenant Governor Houser and in the Assembly by Speaker Lyon.

Slow Down

The mass of last-minute legislation slowed down preparation of bills by Fred B. Wood, State legislative counsel.

Hearings on Governor Warren's $683,710 000 State budget will be begun as soon as practical by the Assembly Ways and Means Committee, headed by Albert C. Wollenberg, San Francisco.

Public hearings on the compulsory health insurance issue will be held during February and early in March by the Assembly Public Health Committee, of which Fred Kraft, San Diego, is chairman. San Francisco hearings will be on March 2-3 and the Southern and Central California hearings during February. . . .—Earl C. Behrens in San Francisco *Chronicle,* January 29.

ITEM LIII

Labor League Gives Health Insurance Plan a Vote of Confidence

Support of the proposed California medical insurance system and of the nomination of Henry Wallace as Sec-

retary of Commerce was voted January 26 at a meeting of the United Labor League of Santa Clara County, meetings at 338 W. Santa Clara St. . . .

The league went on record as supporting the Assembly bill for a "State medical insurance system that carries two very important provisions supported by the State Federation of Labor and the California C.I.O.—capitation payment and that labor and other non-medical representation feature the administration setup."—San Jose *Mercury-Herald*, January 27.

ITEM LIV

3,385 Bills in 1945 Legislative Hopper; But Record Was 4,175 in 1939

Sacramento, Jan. 29.—The clocks in the Capitol chambers stood at 3.

That was the official hour Saturday afternoon when this first bill-introducing part of the 1945 legislative session came to a halt.

But don't let the record fool you. Real windup came eight colorful hours later. "Getting the bills in" turns out to be a pretty zany affair once the lawmakers step into that "never-never" time when the clock hands freeze to its face. . . .

And Clerk Geraldine Hadsell intoned titles hour upon hour. Midafternoon a "call of the house" was voted to hurry things. This locks in the members already present, and sends out the sergeant-at-arms to round up absentees.

"We have a lot of work to do. Let's hurry up and get out of here," admonished Mr. Lyon.

Some members read the funny papers. Others chatted in little groups on the floor. A few rushed up to the desk from time to time with a stack of bills.

"Look at this bunch," one Assemblyman remarked, flipping through a stack of 20 or more, "I haven't an idea what they are all about—just gave them to me, and there isn't time to read them."

Others hunted up co-signers. "Go on this one with me, pal. It's a good bill, really it is. . . . Here, this is that tax bill I told you about. Sign up, huh?" Sometimes it took more of a selling approach to get signers. Sometimes only a name. "Doakes is interested in this."

Not all bills are "processed" by the legislative counsel. Private lawyers work out many.

Wanted Them in Order

One man carried 40 to the desk at once. "I want to be able to find mine, all numbered one right after another."

Others picked out an even number, easy to remember, and thrust important bills in at that point for the small psychological advantage.

Night fell. "We will recess for five minutes," said Mr. Lyon. "That means be back here at 9 p.m." The fiction of preserving the 3 p. m. adjournment was being retained. Everybody—except the legislative counsel—went out to dinner.

* * *

On Friday night, January 26, only 892 bills had been introduced into the Senate; only 1,609 in the Assembly. So heavy was the tide on the last day that the total when business finally ended was 3,385 bills. Last time 3,131 came in; record high was in 1939, with 4,175. Always about 60 per cent roll in the last three days. And the rule is about 25 per cent will become law.

Only five men remained of the 80 when the last Assembly bill was in—(at 10:45 p.m. but don't tell anybody)—No. 2132, "an act pertaining to aid to the aged."

The clerk had a green all-day sucker in his mouth. He took it out, while he told reporters crowded about the desk that it "seems to be about giving 20 more bucks to folks between 60 and 65 years."

A Tie After All

Mr. Lyon, apparently unwearied, asked the [illegible] to form a committee to advise the Senate their [illegible] through.

They were boastful at beating the other house but crestfallen when they passed a similar committee in the hall coming to tell them the Senate was through. It was a tie.

Next Mr. Lyon sent off his loyal five to "inform the Governor this house is concluding its business.

They returned. One took the mike in the lonely, lighted room. "Mr. Speaker," he thundered. "Your committee regrets that it cannot discharge your order. The Governor cannot be found. His door is locked. His office is dark. Why don't we all go home?"

"Why not?" said Mr. Speaker. "This house is recessed as of 3 p.m. today until March 5, at 11 a.m."—San Francisco *News*, January 29.

ITEM LV

Legislative Committees to Open Hearings; Warren Will Campaign for Health Bill

Interim Groups to Carry on Studies During Recess

Members of the State Legislature had returned to their homes on January 29 for the February constitutional recess after one of the shortest opening sessions—nineteen days—in California history. The session ended late Saturday night, after a total of 3,385 bills had been introduced.

Most of the legislators will devote all or most of their time during the recess to service on one or more of the record number of committees which will function throughout the State before the session reconvenes on March 5. . . .

* * *

Assemblyman Fred Kraft, chairman of the Assembly Public Health Committee, will bring his committee to San Francisco for public hearings on March 2 and 3. The Senate Committee on Governmental Efficiency, to which health insurance bills were referred in the Upper House, is expected to hold its San Francisco meetings somewhat earlier.

* * *

Governor Earl Warren, who has made enactment of a health insurance program his major recommendation at this legislative session, said in Sacramento yesterday that he will personally campaign in behalf of the principles embodied in the administration bill. . . .

"I am not going to open any headquarters and I don't know just how I am going to do it," Warren said, "but I feel an obligation to put all the facts before the public and intend to do so. I hope to make all of the facts concerning the prepaid medical care available to the people of California and at the same time to show them that the administration sets up adequate machinery for attaining the desired objective."

* * *

Assemblyman Albert C. Wollenberg of San Francisco, principal author of the administration bill in the Assembly, will explain its provisions Thursday noon at a section meeting of the Commonwealth Club of California. . . .—R. W. Jimerson in San Francisco *Examiner*, January 30.

ITEM LVI

California Health Insurance Plans Debated at Town Hall Meeting in Los Angeles

The Governor's bill for prepaid medical care through compulsory State-wide insurance came in for debate yesterday before Town Hall in the Biltmore.

Albee Slade, legislative director of the Los Angeles C.I.O. Council, spoke for it or a similar plan sponsored by that labor union. Dr. Lowell S. Goin, president, California Medical Association, took the negative. Their main points:

Mr. Slade: More than one-half of the first 3,000,000 called in the draft (38 out of 100 in California) were rejected because of physical disability. Five million 4-F's is the result. Low health standards also affect war industrial output. The manpower shortage is due in good part to it. United States has a bad health record despite medical statistics to the contrary. Infant mortality and deaths over 60 are greater than in many countries of the world. The California plan does not spell socialized medicine. We want the medical profession to continue direction of public health.

Dr. Goin: It is socialized medicine, which is fundamentally un-American. If a doctor must go into a rural district where he can't make a living he must be paid by the State. Statistics are deceptive. A large part of the 4,500 000 or 5,000 000 4-F's are rejected for short-sight and other congenital defects that all the medical attention in the world could not prevent; only selective breeding could do that. Factory absenteeism in good part is due to the common cold, which cannot be prevented or cured. It is a naïve idea that if you can get people over the financial hurdles and to the doctor we will have nearly perfect health. They have had socialized medicine for many years in England and Germany but the 4-F problem or infant mortality in those countries is no better than ours.—Los Angeles *Times*, January 30.

ITEM LVII

No Recess in Health Bill Fight

Sacramento is quiet. The Capitol has been given back to the women. At least it looks like that as high-heeled stenographers and clerks suddenly become the majority in hallways and offices. The 120 legislators are home, the thrice-that-many lobbyists scattered. Even Governor Warren is away—in Washington, D.C.

But not for a second has the legislative game taken time out.

In San Francisco Assemblyman Wollenberg gave his first talk in support of the Governor's health insurance program, which shoulders high above every other item as No. 1 interest in this legislative session.

Publicity Staffs Busy

Throughout the State supporters of compulsory health insurance are chipping in funds and ideas for organized explanation of what it's about, who wants it, and why. Some question-and-answer pamphlets will be prepared, publicity men hired to make the "pro" side vocal. Those against the plan—medical and business groups in the main—reportedly already have their publicity staff at work.

The people, in other words, will get their chance this month to demonstrate favor or disfavor in a heated campaign that won't wait for the March 5 convening of the Legislature again.

* * *

Today unexpectedly strong aid rallied to Governor Warren's side on this tempestuous issue. William M. Malone, state Democratic committee chairman, voiced personal support for compulsory health insurance and predicted that "Democrats will do everything they can to help."

"Democratic Program"

"Better health protection for the people is one of the things the Democrats have sought for years," he said. "We are not going to buck compulsory health insurance now just because the spokesman for another party has advanced a principle we favor.

"I hope the Democrats in this State can help put it over."

Mr. Malone will probably discuss party support with Democrat members of the Legislature, particularly Assemblyman Robertson of Santa Barbara, Democratic floor leader, when the second part of the session begins next month.

* * *

Women's groups are getting February meetings scheduled on the health insurance question. Local members of the American Association of Social Workers will have an open forum discussion. The Northern California Union Health Committee, headed by Daniel Del Carlo, and representing the two major union groups plus the railroad brotherhoods, will have an executive meeting this week-end to decide their steps on a program they have already publicly supported.

* * *

Meanwhile, in his talk before doctors and businessmen at a St. Francis Hotel meeting yesterday Mr. Wollenberg predicted that nearly seven million, out of California's total 8½ million population, will be able to come under the health insurance setup. He expects 5½ million included on social security basis (all workers eligible to unemployment insurance plus their families) plus another million entering voluntarily. It will cost, he thinks, about $30 to $40 a year per individual to operate successfully.

ITEM LXVIII

Governor Warren's Public Health Bill Explained By Assemblyman Wollenberg

Assemblyman Outlines Warren Program at S. F. Luncheon Session; Sees Favorable Vote

The prepaid medical service bill sponsored by Governor Earl Warren was given its first public presentation yesterday, when Assemblyman Albert C. Wollenberg of San Francisco, who will handle it in the Lower House, explained the measure at a luncheon meeting attended by legislators, public officials, doctors, experts in public administration, and many others. . . .

"I look for a long and heated debate in the Legislature and throughout the State," Wollenbreg told his hearers at the St. Francis Hotel, "but I feel very definitely that legislation of this type will come out of the 1945 legislative session. The people want it—and the Legislature keeps closely in touch with what the public wants."

Most of the audience listened to Wollenberg's talk without comment, but the question period which followed showed about an even division between those who obviously favored some sort of compulsory health insurance, and those who did not. . . .

"Never in history has one single piece of legislation met the Statewide approval that this proposal has had in such a short time," Wollenberg said.

Declaring that the C.I O. will place its measure on the ballot by initiative if the Legislature fails to act this year, Wollenberg added:

"Sound judgment dictates that a new departure of this kind, untried in America, should be subject to change and control by the Legislature, rather than placed in the constitution where it cannot be amended except by another vote of the people."—R. W. Jimerson in San Francisco *Examiner*, February 2.

ITEM LIX

Cost of Governor Warren's Health Plan Figured

An estimate of the cost of Governor Warren's prepaid medical care plan was given today by Assemblyman

Albert C. Wollenberg, coauthor of the measure in the Assembly.

He said that the service would apply to between 6,000,000 and 7,000 000 Californians, who, it was figured, would contribute between $200,000,000 and $230,000,000 through a 3 per cent payroll tax.

He explained that the Legislature would be empowered to increase the tax or to provide for appropriations from the State's general fund should it become necessary to meet any deficit.

Under the Governor's plan, the State's credit is pledged to assure operation of the system until June 30, 1949. Its benefits would begin January 1, 1947, with tax collections effective six months previous.—San Francisco *Call-Bulletin*, February 2.

ITEM LX

Health Insurance—As Proposed for California

(Bulletin by California Medical Association, January 30, 1945)

Foreword.—As of January 26th a total of 13 bills had been introduced into the 56th Legislature upon the subject of Health Insurance, Health Services or closely related thereto. We understand from newspaper reports that other bills on this subject were introduced in the closing hours of the January session, but at this date have not had an opportunity to examine them.

The 13 bills are:

Senate Bill 218: (By Hatfield, Crittenden and Sutton) relating to admission to county hospitals and medical care at county expense.

Senate Bill 219: (By Hatfield and Sutton) authorizing and governing the practice of group medicine.

Assembly Bills 1110 and 1111: (By Stephenson and Lowery) companion bills to the above.

Assembly Bill 800: (By Wollenberg, Fourt, J. C. Lyons, Doyle, Brown, Dunn, Fletcher, Gaffney and Waters) Governor Warren's Compulsory Health Insurance Bill.

Senate Bill 500: (Salsman, Shelley and Dillinger) Governor Warren's Compulsory Health Insurance Bill.

Senate Bill 699: (By Carter) relating to County Hospitals and admission of pay patients thereto.

Assembly Bill 449: (By Thomas, Dekker, Anderson, Massion, Fletcher, Hawkins, Kilpatrick and Rosenthal) the C.I.O. bill for Compulsory Health Insurance.

Assembly Bill 1200: (By Sam L. Collins, Field, Werdel, Erwin, Knight, Stewart, Stream and Watson) The California Medical Association bill for the encouragement of voluntary medical, surgical and hospital plans.

Assembly Bill 1414: (By Rosenthal) duplicate of the Olson bill of 1939.

Assembly Bill 1525: (By Massion and Dunn) providing for a comprehensive health service to the people of California.

Assembly Bills 1595 and 1596: (By Wollenberg, J. C. Lyons and Fourt) making the necessary appropriations for Governor Warren's Health Insurance plan.

* * *

Since most of the discussion to date has centered around *Compulsory Tax Increase Bills,* we will concentrate in this memorandum on AB 449 (the C.I.O. Bill); AB 800 and SB 500 (Governor Warren's Bills) and AB 1200 (the California Medical Association Bill, which contemplates *no new taxes*).

* * *

I. Compulsory Tax Increase Bills

A. B. 449

Authors: Assemblymen Thomas, Dekker, Anderson, Massion, Fletcher, Hawkins, Kilpatrick and Rosenthal.

Sponsor: C. I. O.

Major Features:

(1) *Administration:* Creates *new* bureau (California Health Insurance Commission) with power to manage and regulate the compulsory health plan. California Health Insurance Commission to consist of nine persons appointed by Governor, two from labor, two from management, two from agriculture, one from medical profession, 1 full-time professor in a medical school, and 1 from the general public (practicing physicians have one member out of nine). An executive director (who must *not* be a physician or dentist) to have full power to manage the day-by-day operations; his salary to be $15,000 per year. A medical director to be appointed (salary $12,000 per year) but his powers, if any, are not specified.

A Medical Advisory Council (two M.D.s, 1 osteopath, 1 dentist, 1 professor, 1 hospital manager, 1 pharmacist, Director of Public Health, and 1 representative of "group practice of medicine") to be appointed by Governor. Its powers limited to "advising" the Medical Director concerning professional and hospital standards of service.

The State to be divided into "areas," each area to have a Medical Director and an Area Medical Council (with power to "advise" on professional matters). The Commission may establish "Appeal Bodies" to hear and determine all disputes subject to *final* appeal to the Commission.

* * *

COMMENT CONCERNING AB 449—THE ELABORATE ADMINISTRATION SET-UP INDICATES AN OPENING WEDGE FOR A HUGE NEW BUREAUCRACY

(2) *Financing:* Costs are financed by (a) a payroll tax of 1½ per cent on employers and 1½ per cent on employees, (b) appropriations from general taxes (for administration expenses), and (c) payments from counties, etc., to cover cost of indigent care. Political subdivisions must pay such amounts as the Commission fixes, but not more than 3 per cent of *average* wages.

(3) *Persons Covered:* All employees who are now subject to Unemployment Insurance Act, their wives and children under 18; also, all indigents (including old age pensioners); also, all state and county employees, their wives and children under 18.

(4) *Benefits:* Medical care, as follows:

(a) "General practitioner" services including "preventive," diagnostic and therapeutic treatment and care and physical exams, (b) "Special medical care," i.e., services requiring unusual professional skill or experience by "a legally qualified physician or dentist who is professionally capable of rendering such srevice," (N.B. Presumably, the Medical Director decides what doctors are specialists and in what specialties), (c) Laboratory services including x-ray, clinical laboratory studies and physiotherapy, hospital care up to twenty-one days, dental and nursing care to the extent the Commission finds feasible.

(5) *Eligible Purveyors of Benefits:* (a) All M.D.s, (b) all osteopathic physicians and surgeons, (c) all dentists, (d) such hospitals as are *approved* by the Commission, (e) all *group* clinics composed of M.D.s, and (f) all medical school faculty members.

(6) *Method of Paying for Benefits:* All "general practitioner" services are paid on a *capitation* basis (i.e., each person selects a doctor and the doctor is then paid $——— per year for each person selecting him, irrespective of the work, if any, done in such year). "Specialist" services and laboratory services will be paid on a fee schedule. The fee schedule need *not* be uniform throughout the State.

(N.B. Furnishing of benefits is a "collective responsibility" of *all* physicians in the area!)

(7) *Effective Dates:* (a) Tax payments, July 1, 1945, (b) Benefits, July 1, 1946.

(8) *Exemptions:* None.

GOVERNOR EARL WARREN'S BILL

A. B. 800

Authors: Assemblymen Wollenberg, Fourt, J. C. Lyons, Doyle, Brown, Dunn, Fletcher, Gaffney, and Waters.

S. B. 500: Companion Bill

Authors: Senators Salsman, Shelley and Dillinger.

Sponsor: Governor Warren.

Major Features:

(1) *Administration:* Creates a *new state bureau*, the California Health Service Authority, with power to operate, manage and regulate a compulsory health insurance plan, *subject to the right of the Governor to veto or suspend acts of the Authority*, the Authority to consist of eleven members and a manager, all appointed by the Governor. The eleven members of the Authority shall include three persons from management, three from labor, two members of the medical profession, one physician experienced in hospital management, one dentist, and the Director of Public Health. The executive head of the Authority is the manager (salary $12 000 per year), who is not required to be a physician. *The manager is directed to administer the act* and to employ such personnel as may be necessary. (The Commission is a part-time affair that would only meet once a month.)

(2) *Financing:* Costs are financed by (a) a payroll tax of 1½ per cent on employers and 1½ per cent on employees, and (b) such amount from the general funds of the State as may be necessary. (Bill states "The faith and credit of the State are hereby pledged to assure the operation of the . . . system until . . . June 30, 1949.")

* * *

CONSENT CONCERNING GOVERNOR WARREN'S BILLS
(A. B. 800 AND A. B. 500)

The Governor proposes a 3 per cent tax on payrolls up to the first $4,000 of wages paid in each year. In 1944 the unemployment payroll tax (total tax being about 3.15 per cent) produced about $170 000 000. In 1940 the same tax produced only $76,000 000. Under the Governor's bill he proposes to cover at least six million people with full medical care, hospitalization, and some dental care. Even at coolie wages to the doctors, the costs of the bill will run at least $250 000,000 to $300,-000 000 per year; yet the tax he proposes cannot raise more than $150 000 000 even in boom times, and if we return to 1940 levels will only raise about $60,000 000 or $70 000 000. That means that his provision for resort to the general funds of the State will cost the State between $100 000 000 and $200,000,000 a year for the next three or four years.

(N.B. The 1½ per cent payroll tax applies to the State, every State agency, every fund any employees of which are subject to the State Civil Service Act, every political subdivision, public or municipal corporation. This would come out of the tax funds levied for support of such employing units.)

(3) *Persons Covered:* All employees who are now subject to the Unemployment Insurance Act, their wives and children under eighteen; also included are all State, county and municipal employees, their wives and children under eighteen.

(Comment. Employers are NOT covered. This is of great importance to employers of small groups.)

(4) *Benefits.* Medical care as follows: "General practitioner" services including "preventative, diagnostic, therapeutic, or other medical treatment or care"; "specialist" services in addition to those of the general practitioner, laboratory and x-ray services, hospital care up to twenty-one days drugs and medicines, dental services "for the extraction of teeth and for the treatment of acute infections of the teeth, gums, and lavcolar processes and the bone adjacent thereto, or fractures of the jaws." Additional services may be provided by the Authority from time to time.

(5) *Eligible Purveyors of Benefits:* (a) All M.D.s, (b) All osteopathic physicians and surgeons, (c) all dentists, (d) all optometrists, and (e) such hospitals as are approved by the Authority and meet the standards prescribed by the Authority.

(6) *Method of Paying for Benefits:* All services of doctors of medicine, osteopaths, dentists and optometrists will be paid for in accordance with a fee schedule adopted by the Authority. One section of the bill guarantees each person covered the right of free choice from amongst such physicians, dentists and optometrists as register for services under the act. *The Authority may prescribe any fee schedule that it desires, and the fees need not be uniform throughout the State.*

(7) *Effective Dates:* (a) Tax payments commence July 1, 1946, (b) Benefits commence January 1, 1947. It is provided, however, that the Governor may delay the effective dates for not more than one year if the United States is still at war on April 1, 1946; also, if the bill should pass the Legislature and be subject to a referendum the effective dates are automatically postponed for one year.

(8) *Exemptions:* (a) Religious: All people who depend for healing upon prayer are exempt both from the benefits and the payroll taxes (the employer of a religious objector must still pay *his* 1½ per cent). (N.B. This exemption may violate the Equal Protection of the Laws clause of the Federal Constitution.)

(b) Employees leaving the State: Any employee who leaves the State and has paid into the fund an amount less than sufficient to make him eligible for benefits (the minimum is a wage of $300 per quarter for six months) is entitled to a refund of all taxes paid.

(N.B. This is a most amazing principle for a pooled fund insurance scheme.)

(c) Employer-operated medical plans: Industrial medical plans owned and operated by an employer may be exempted from both the benefits and the tax by contracting with the manager of the Authority to continue such industrial plan in existence.

(d) Railroad employees: Both railroad and maritime employees are exempted from the definition of the term "employment," and therefore apparently are not entitled to any benefits under the bill.

(9) *Miscellaneous:* (a) Employee Health Plans: It is made a misdemeanor for any employer to require membership in any health plan as a condition of employment.

(b) Control over Beneficial Standards: The bill permits California Health Service Authority to expel any registered physician who rebates fees, seriously neglects the welfare of the patient, or intentionally violates *any* rule or regulation of the Authority. (N.B. Under this provision the Authority could require doctors to disclose professional secrets and expel them from the system if they keep their patient's confidence.)

(c) Penlaties: It is a misdemeanor to violate any provision of the act or of the regulations thereunder or to fail to make full reports to the Authority.

* * *

C.—A. B. 1414

Author: Assemblyman Rosenthal.

Sponsor: Not known, but the bill is identical with Governor Olson's 1939 compulsory health insurance bill.

Major Features:

(1) *Administration:* Adds a Division of Medical Service to the Department of Employment. Provides for a Medical Director as the chief of the division, the Medical Director being charged with the administration of the professional phases of the plan. Otherwise, the present California Unemployment Commission is given

full power to administer the so-called "social insurance benefits." The bill as in the form of an amendment to the Unemployment Relief Act; hence utilizes the existence of the Unemployment Commission as the administrative body.

(2) *Financing:* Proposes a 1 per cent tax on employers, a 1 per cent tax on employees and provides for a contribution from the general funds of the State equal to 1 per cent of all wages paid to the State.

(3) *Persons Covered:* All employees now subject to the Unemployment Insurance Act and not now earning more than $3,000 per year, their wives and children under twenty-one.

(4) *Benefits:* Medical benefits include the services of general practitioners, the services of specialists, laboratory and x-ray services, hospitalization, nursing services, drugs and medicines, and dental services as follows: extraction of teeth, treatment of osteomyelitis of the jaw, trench mouth and jaw fractures; and optometrical services. In addition to the medical benefits, the bill also provides for cash sickness payments to employed persons when ill or injured, these payments to be made out of the Unemployment Fund and to be equal in amount to the present unemployment benefits.

(5) *Eligible Purveyors of Benefits:* All M.D.s, all osteopathic physicians and surgeons, licensed optometrists, licensed dentists and approved hospitals.

(6) *Method of Paying for Benefits:* General practitioners to be paid on the capitation system; specialists, dentists, optometrists, x-ray and laboratory services, and hospitalization to be paid under a fee schedule, the fee schedule to be fixed by the California Employment Stabilization Commission and Medical Director. Various provisions of the bill permit the state to contract with closed panel group clinics for the purpose of permitting such clinics to render all of the medical services provided in the bill on a fixed amount per annum, closed panel group clinics being expressly incorporated by various sections of the bill.

* * *

D.—S. B. 218

Authors: Hatfield, Crittenden and Sutton.

Sponsor: California Farm Bureau.

Major Features:

This bill relates only to county hospitals. Its purpose is to open all county hospitals to all residents of each county, regardless of income. The bill divides all citizens into three classes: A—indigents; B—poor but able to pay some costs; C—able to pay full costs of medical care and hospitalization. Classification into A, B or C is determined by reference to each person's income, amount of property owned and wealth of near relatives legally liable for his or her support.

Those in Class A are entitled to hospitalization and medical care at the expense of the county.

Those in Class B are entitled to medical care and hospitalization at the expense of the county, but are required to contribute to the county such portion of such expense as they are able to pay.

Those in Class C are entitled to hospitalization in the county hospital, but must pay the full cost of such hospitalization. People in Class C are not entitled to any medical care from the county, but are privileged to have their own physicians or dentists treat them in the county hospital while hospitalized.

As to people in Class C, physicians and dentists are permitted to charge private fees. As to those in Class A and Class B, medical care is rendered by the county hospital staff and no charge may be made.

All costs of operating the county hospital constitute a charge against county taxes. The bill also provides that in each county there shall be a Board of Public Welfare of seven persons, two from agriculture, two from medicine, one from osteopathy, and two from business and labor groups. Classification of patients admitted into the county hospital into A, B or C would be made by a medical social service investigating agency acting under the jurisdiction of the Board of Supervisors; provided that any person not satisfied with the medical social service classification may appeal to the county Board of Public Welfare.

In substance, this bill would change county hospitals from charity institutions to a combination charity hospital and private hospital.

* * *

II. Voluntary Bills

A. B. 1200

Authors: Assemblymen Sam L. Collins, Erwin, Field, Knight, Stewart, Stream, Watson and Werdel.

Sponsor: California Medical Association.

Major Features:

(1) *Administration:* As this bill proposes aid and assistance to existing voluntary nonprofit plans, there is *no new bureau created and no additional governmental employees contemplated.* The bill is in the form of an amendment to the Unemployment Insurance Act, and the little administration that is necessary will be done by the existing Employment Stabilization Commission.

(2) *Financing:* Again, as this is a voluntary plan, *no new taxes are contemplated.* The existing tax structure of the Unemployment Insurance Act, which has proven to be more than necessary for unemployment relief, will be utilized under this bill for assisting in spreading the cost of medical care.

(3) *Benefits:*

(a) Voluntary nonprofit medical and hospital plans: To encourage people to enroll in these plans, of which there are many in the State, the bill cuts the employee's 1 per cent payroll contribution to the Unemployment Fund in half; thus an emplyoee who enrolls himself and his family in a nonprofit medical and hospital plan would thereafter be taxed ½ of 1 per cent instead of 1 per cent by the State Unemployment Act. If he earns $200 per month, this means a tax saving of $1, which is automatically applied against his monthly dues to the voluntary plan. In the average case this would amount to about one-fourth to one-third of the total dues charged by existing voluntary plans. This can be done within the existing tax structure. Using 1944 as an example, if this bill had been in effect the ½ of 1 per cent reduction in employees' unemployment contributions would have cost the fund about $25,000 000. In all years since 1936 the costs of the Unemployment Fund have been sufficiently under the tax receipts so that a reduction of ½ of 1 per cent could have been made without jeopardizing the Unemployment Fund. In fact, California and three other states are the only ones who tax the employee anything for unemployment relief, so that we have in this State the full 1 per cent employees' tax over and above the comparable resources of the unemployment funds in forty-four of the States. This bill proposes to make some use of this existing excessive tax, and to allow the people to get some benefits from it.

(b) Allows employers to make payroll deductions for all employees for payment of dues or premiums for approved hospital, medical or surgical prepayment plans. Exceptions under this rule would be made for employees who state in writing their objections to inclusion in such plans. This feature follows the election procedure of the National Labor Relations Act, providing that majority of employees may bind all employees in joining approved nonprofit plans.

(c) Provides that regular unemployment benefits will be paid to employees who are hospitalized for illness and

who are not covered for hospitalization by an approved nonprofit plan. A preliminary actuarial study indicates that this provision of the bill will cost the Fund not more than $2,500 000 per year, based on the incidents of hospitalization and the number of people covered. Actually, it will probably cost the fund less than $2,500 000, because most employees will join voluntary plans to get the tax reduction provided in another part of the bill, and as to such employees sickness benefits are not payable as they are already covered; $2,500 000 is therefore the maximum cost. In 1944 the unemployment tax collections totaled about $170 000 000, so that $2,500 000 is less than 2 per cent of the annual funds available.

(4) *Approved Voluntary Plans:* The bill provides the following types of voluntary plan are approved for the purpose of qualifying persons who enroll for the benefits set forth above:

(a) Any nonprofit corporation holding a certificate issued by the State Board of Medical Examiners, the State Board of Osteopathic Examiners, or the State Board of Dental Examiners, under Subdivision (4) of Section 593a of the Civil Code.

(b) The Blue Cross plans, i.e., nonprofit hospitalization plans operated by the hospitals, and

(c) All insurance company medical, surgical and hospital reimbursement policies.

Each and all of the foregoing types of plan qualify, and people who join them will, under the bill, be entitled to the tax reduction above described. In order to prevent fraudulent plans from springing into existence it was necessary to describe the type of voluntary plan that meets with the State's approval. Descriptions used in the bill are sufficiently broad to cover all types of plan than provide free choice of physician and which give to the public reasonable value for their money paid.

(5) *Miscellaneous:* The incentives that are given to existing private enterprise by this bill will result, if the bill becomes law, in the bulk of the low and middle income population of the State enrolling in voluntary plans. *This can all be accomplished without increasing the tax structure and further penalizing California business and industry.* At the same time, because private enterprise always operates more efficiently than governmental monopolistic bureaus, the people will get more value for each dollar paid than they ever will through a compulsory plan.

* * *

B.—S. B. 219

Authors: Senators Hatfield and Sutton.

Sponsor: California Farm Bureau.

Major Features:

The purpose of this bill is to remove all doubts as to the legality of closed panel group or contract medical practice. Under the bill, any group of physicians or any corporation may enter into contracts with subscribers for the furnishing of health services on a prepayment basis, if such group of physicians or corporation has first obtained from the State Department of Public Health a license authorizing it to transact a prepayment health service plan. The bill prohibits operations by any prepayment plan that does not qualify for a license from the Department of Public Health. There is no requirement in the bill that health service associations offer free choice of physician or hospital; on the contrary, the bill contemplates closed panel or salaried medical staffs to render services to the people who join health service associations. It is provided that associations formed under the bill shall not be subject to the insurance laws of the State. It is also provided that health service associations may be formed either by members of the general public for the purpose of contracting with physicians, or by groups of physicians for the purpose of contracting with members of the public.

It is not clear whether the bill, if enacted into law, would affect California Physicians' Service and existing insurance company reimbursement contracts. It is clear that the bill, if enacted, will legalize operations of closed panel clinics such as Ross-Loos, Chartres-Martin, Stowe-Lipsett, and Ferd W. Callison and Staff.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (13)

Alameda County (10)

Ash, Donald W., *Oakland*
Christensen, Burt H., *Oaklnad*
Clark, Donald K., *Oakland*
Frary, Louise G., *Alameda*
Grieco, Sebastian C., *Oakland*
Heilbronn, Alexander, *Oakland*
Libby, Charles W., *Oakland*
Root, Grosvenor T., *Oakland*
Violin, Karl, *New York City, N. Y.*
Wilson, Lois S., *Berkeley*

San Bernardino County (1)

Meister, Lester, *Fontana*

San Francisco County (2)

Berger, Max M., *Fort Miley*
Mulvany, Thomas A., *San Francisco*

Transfers (2)

Moran, James A., *from Contra Costa County to Monterey County*
Oppenheimer, Sali, *from San Francisco County to Alameda County*

Retired Members (4)

Carpenter, Harry L., *Contra Costa County*
Gray, John H., *Monterey County*
King, J. A., *Ventura County*
Sewall, Edward C., *Santa Clara County*

Resignations (1)

Weiss, Charles, *San Francisco County*

In Memoriam

Blake, Charles Robert. Died at Richmond, December 27, 1944, age 76. Graduate of the University of California Medical School, Berkeley-San Francisco, 1891. Licensed in California in 1892. Doctor Blake was a Retired Member of the Contra Costa County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✤

Briggs, Wallace Rideout. (Lieutenant Commander, United States Navy.) Died at Long Beach, December 18, 1944, age 50. Graduate of the Harvard Medical School, Boston, 1919. Licensed in California in 1920. Doctor Briggs was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✤

Dietz, Henry Louis. Died at Oakland, December 12, 1944, age 72. Graduate of the California Eclectic

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Medical College, Los Angeles, 1896. Licensed in California in 1896. Doctor Dietz was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Garibotti, Angelo David. Died at Santa Cruz, December 14, 1944, age 32. Graduate of Creighton University School of Medicine, Omaha, 1938. Licensed in California in 1939. Doctor Garibotti was a member of the Santa Cruz County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Lynch, Frank Worthington. Died at San Francisco, January 14, 1945, age 73. Graduate of the Johns Hopkins University School of Medicine, Baltimore, 1899. Licensed in California in 1915. Doctor Lynch was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Sawtelle, Henry Fenno. Died at Arroyo Grande, December 2, 1944, age 67. Graduate of the University of Illinois College of Medicine, Chicago, 1902. Licensed in California in 1935. Doctor Sawtelle was a member of the San Luis Obispo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Soucey, Harold Carold. Died at Los Angeles, December 25, 1944, age 51. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1928. Licensed in California in 1936. Doctor Soucey was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Stearns, Lester Miles. Died at La Jolla, January 4, 1945, age 62. Graduate of the University of Illinois College of Medicine, Chicago, 1905. Licensed in California in 1943. Doctor Stearns was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Taylor, David Armstrong. Died at San Francisco, January 2, 1945, age 74. Graduate of the Milwaukee Medical College, Wisconsin, 1905. Licensed in California in 1917. Doctor Taylor was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Thorne, Isaac Walton. Died at San Francisco, December 23, 1944, age 73. Graduate of the Cooper Medical College, San Francisco, 1896. Licensed in California in 1896. Doctor Thorne was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Williams, Norman Harris. Died at Los Angeles, December 18, 1944, age 68. Graduate of the Johns Hopkins University School of Medicine, Baltimore, 1913. Licensed in California in 1918. Doctor Williams was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the Amreican Medical Association.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

	November 1943	*November 1944*
Commercial Program	54,500	101,000
Rural Health Program	2,400	2 038
War Housing Program	20,790	15,000
Total Membership	77,690	118,038

With the confusion that now exists in the ranks of the medical profession as a result of the actions of the recent special session of the House of Delegates, and proposed legislation, it is difficult to clearly define the state of medical affairs in California.

California Physicians' Service, of course, finds itself at the fulcrum point of various vital forces that are attempting to shape the destiny of the private practice of medicine. Whether California is being used as a trial horse through influence from the East or not, or whether this originates within the State itself is not clearly discernible, but there is no doubt but what a terrific upheaval is now going on.

Under these conditions, it is rather difficult to lay a course, because there is apparently no direction that is the obvious one to take. There is no doubt, however, that during the preliminary discussions C.P.S. may play a very prominent part in all of the discussions, and if there are any conclusions reached, it will undoubtedly be somewhere in the picture. Toward this end, C.P.S. is continuing on with its business as usual, effecting its rate changes and continuing to develop and perfect its various techniques.

Because of the unknown quantities in the picture, and because C.P.S. has been frequently mentioned as a probable component part of anything that does happen—granting the possibility that it may happen—it is again apparent that the unqualified support of every individual physician is necessary. One of the big weaknesses that C.P.S. is frequently subjected to is lack of coöperation of an individual doctor, a group of doctors or a locality of doctors. These weaknesses are seized upon by opponents to a physician-sponsored plan as being evidence that the physicians themselves do not support their own program, and this is very damaging when it is brought up under the right circumstances.

The C.P.S. that the supporting members of the profession have developed is gradually beginning to prove its worth, by mere reason of the fact that it has existed for six years and has acquired a sufficient volume of people to provide an experience which we are sure will not be overlooked in any of the future events. The actuarial and technical data that C.P.S. has acquired is incontrovertible evidence, which has been kept by a fool-proof system. This evidence, if and when requested and summoned, can be of great value if there is negotiating or bargaining to be done relative to the cost of medical care and the methods of its distribution.

For these reasons C.P.S. should continue on, even more active than in the past, should gear itself to greater and greater membership, and gear itself to greater and greater support of the medical profession. It is obvious that no immediate action is going to take place, regardless of what legislation may be proposed or even passed. Under the latter condition, the medical profession still has at least a year, or maybe two years, in which to entrench itself in the good regard of the public.

A. E. Larsen, M.D.,
Executive Medical Director.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session, previous'y scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all brodacasts being given on Saturdays:

KFAC presents the Saturday programs at 10.15 a. m., under the title, "Your Doctor and You."

In February, KFAC will present these broadcasts on the following Saturdays: February 3, 10, 17, and 24.

The Saturday broadcasts of KF1 are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *More Books:* Reinhold issues M. Sahyun's *Outline of Amino Acids and Proteins* and P. J. Flagg's *Art of Resuscitation.* Farm Foundation, Chicago, offers *Medical Care and Health Services for Rural People.* Grune & Stratton, New York, publish L. Lichwitz's *Pathology and Therapy of Rheumatic Fever* (with full bibliography). C. C. Thomas (Springfield, Ill.) puts out 3rd Ed. of R. Major's fine *Classic Descriptions of Disease.* L. Loeb's *Biological Basis of Individuality*, and P. McDonough's *Poet Physicians.* Nicholson of London offers B. Graves' *Comments on Medicine, Surgery and Education.* Faber, also of London, prints H. Renner's heavy tome on *The Origin of Food Habits.* Heineman, still of London, sells A. E. Wright's *Studies on Immunization. 2nd Series* (with Chemotherapy appendix). Livingstone of Edinburgh has W. Sargant and E. Slater's *Physical Methods of Treatment in Psychiatry* (!). Almquist of Upsala offers biography of The Swedberg (1884-1944) with collection of biochemical papers. J. Vicente of Buenos Aires, issues F. J. Manfredi's *Injertos Paratioideos.* El Ateneo, also of Buenos Aires, offers P. Negroni's *Micosis Cutaneas y Viscerales*, E. Braun-Menendez & Co's. *Hipertension Arterial Nefrogena*, A. J. Bandoni's *Terapeutica Antiparasitaria*, E. B. Del Castillo's *Endocrinolgia Clinica*, and Vols. 3 and 4 on symptoms and treatment of A. Gareiso's *Manual de Neurologia Infantil.* Yale Press issues Woglom's trans. of C. Oberling's *Riddle of Cancer.* Hadham, of New York, sells F. Rider's *The Scholar and the Future of the Research Library.* Hopkins Press, Baltimore, issues H. Friedenwald's *Essays.*

2. *More Antibiotics:* S. Waksman & Co. isolate chaetonin from fungus Chaetonium cochliodes, which like penicillin is gram-positive effective and contains N & S (*J. Bact.*, 48:527, 531, 1944). Waksman's discussion on distribution of antagonistic fungi in nature is in *Mycologia* (35:47, 1943). G. F. Gause and M. Brazhnikova (Moscow) recommend 500 gamma per cc. solution locally of gramacidin S for infected wounds (*Nature*, 154:703, Dec. 2, 1944). Merck's H. B. Woodruff finds streptothricin effective against mycobacteria *in vitro* (*Proc. Soc. Exp. Biol. Med*, 57:88, '44). Merck's H. J. Robinson indicates streptomycin's advantages over streptothricin (less toxic, more active) (*Ibid.*, p. 226). S. Waksman then notes activity of streptomycin on M. tuberculosis (*Ibid.*, p. 244). W. T. McCloskey and M. Smith show sensitizing properties of penicillin (*Ibid.*, p. 270). H. J. Greene and G. L. Hobby find penicillin passes placenta (*Ibid*, p. 282). E. B. McQuarrie & Co. report full study of penicillinase (*Arch. Biochem.*, 5:307, 1944).

3. *More on Trauma:* M. Prinzmetal & Co. suggest 2 types of burn shock, one due to local fluid loss (Surg., 16:906, '44), and recommend sulfamerazine locally and systemically immediately after crush injuries, to prevent shock (*Ibid.*, p. 914). A. Forero & Co. correlate cardiac injury with extent of precordial trauma (*Rev. Argentina Card.*, 11:77, '44). C. G. Tedeschi shows same for brain and head trauma (*Proc. Soc. Exp. Biol. Med.*, 57:264, '44). E. G. Bywaters and J. K. Stead show renal failure

* These items submitted by Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

when myohemoglobin, from muscle crush, is excreted in acid urine (*Quart. J. Exp. Physiol.*, 33:53, 1944).

4. *Just More:* S. J. Sarnoff and E. J. Poth find succinylsulfathiazole protective to bowel after blocking venous return (*Surg.*, 16:927, '44). A. S. Wiener describes the Rh series of allelic genes (*Science*, 100:595, Dec. 29, '44). E. Boehm and R. Williams recommend propyl gallate as effective anti-oxidant (*Quart. J. Pharm.*, 17:171, '44). H. H. Anderson and T. K. Chuan find mapharsen effective amebacide in vitro (*Am. J. Trop. Med.*, 24:367, '44). L. W. Kinsell & Co., recommend 12.5 mgm daily testosterone proprionate to prepare thyrotoxic patients for operation, in addition to iodine and thio uracil (*J. Clin. Invest.*, 23:880, '44). G. N. Lewis and M. Kasha offer important concept on phosphorescence and triplet state (*J. Am. Chem. Soc.*, 66:2100, '44). H. F. Blum gives evidence against sterol conversion hypothesis of carcinogenesis by ultraviolet radiation (*J. Nat. Cancer Inst.*, 5:89, '44). J. B. Johnson and W. S. Wallace show how Tb in medical students may be controlled (*Texas S. J. Med.*, 40:428, '44). N. F. Maclagan offers serum colloidal gold reaction in diagnosis of parenchumatous liver disease (*Brit. J. Exp. Path.*, 25:15, '44; *BMJ*, 2:363, '44), and also thymol serum turbidity test (*Nature*, 154:670, Nov. 25, '44). B. D. Davis discusses variety of biologic false positive serologic tests for syphilis (*Med.*, 23:359, '44). Young Turk abstracts appear (*J. Clin. Invest.*, 23:926, '44). J. T. King & Co. confirm Taylor's work on tumor production by inoculation of tumor filtrate (*Proc. Soc. Exp. Biol. Med.*, 57:3, 1944). L. C. Miller and M. L. Tainter embellish ED_{50} idea (*Ibid.*, p. 261). How about "certain safety factor"?

Dr. Robert A. Peers of Colfax Elected Trustee of A.M.A.—Dr. Robert A. Peers, tuberculosis specialist, and an ex-president of the California Medical Association, has been elected a director in the American Medical Association to succeed the late Dr. E. M. Pallette of Los Angeles.

Dr. Peers is in Los Angeles attending a meeting of the California Medical Society.—Sacramento *Bee*, January 6.

Don Ameche's Tribute to the Medical Profession.—The following tribute to the medical profession was given by Don Ameche in the Chase and Sanborn, Edgar Bergen-Charlie McCarthy radio program on Sunday afternoon, January 28, 1945.

Upon request, a copy of Don Ameche's remarks was sent to the Editor of C. & W. M. by the National Broadcasting Company. Don Ameche's remarks follow:

Don Ameche: "Doctors haven't time for you self-made invalids these days, Charlie [Edgar Bergen-Charlie McCarthy Hour] they're too busy both here at home and overseas. No corps of men and women in this war is better serving the cause of victory and humanity than the Medical Corps. Our uniformed forces are getting the best medical attention in the world. The work of doctors and nurses in action areas, ashore and afloat, is dangerous and nerve-racking. While here at home we should never forget that to put all that fine medical aid at the disposal of our fighting men had meant imposing a tremendous strain on the few doctors left to hold high the standards of health and to fight epidemic. The doctors here at home are doing a magnificent job. Each physician today is caring for from three to four times as many patients as he used to attend. These over-worked men need our earnest help. How can we help our doctors? Easily . . . by appreciating their problems and coöperating to solve them. Go to see your doctor in his office, whenever possible, instead of asking *him* to come to see *you*. Call him only when you're sure it's necessary. But when you *are* sure it's necessary, call him immediately and be prepared to give him an intelligent, brief, but complete outline of your symptoms. We might even relieve our doctors of financial worry by paying them as promptly as we expect people to pay what they owe us. But above all, try to help your doctor by being as patient and understanding of *his* problems in *this emergency* as he is patient and understanding of your problems at *all* times."

"Is There a Doctor?"—"Who is a good physician?" is one of the first questions asked by newly arrived residents. The San Francisco Medical Society in 1943, recognizing that thousands of newcomers would be making that query in San Francisco, set up a 24-hour telephone advisory service. This contribution to community welfare has had noteworthy success, as figures just released by the society indicate.

Last year 11,664 calls were answered. Not all were from new citizens, either. Old time residents, whose regular doctors went to war, were frequently equally at a loss to know where to find competent medical service. They relied upon the Society's service.

Callers are given the names of three available physicians from whom to choose. Thereafter all arrangements are between the caller and the physician chosen. The society's telephone number, both day and night, is WAlnut 6100.

This is a practcial home front volunteer community service for which the medical profession deserves great thanks.—Editorial in San Francisco *News*, February 2.

Stanford Popular Lectures.—The Stanford University School of Medicine announces the Sixty-third course of Popular Medical Lectures to be given at Lane Hall, San Francisco, on March 2, March 16, March 30, and April 13, 1945 at eight o'clock sharp. Program follows:

Friday Evening, March 2, 1945: "Mental Disturbances in Relation to the War," by Karl M. Bowman, M.D.

Friday Evening, March 16, 1945: "Medical Services to the Armed Forces," by Charles C. Hillman, Brigadier General, M.C., U.S.A.

Friday Evening, March 30, 1945: "Penicillin," by Lowell A. Rantz, M.D.

Friday Evening, April 13, 1945: "The Rh Factor in Marriage and Childbearing," by T. Henshaw Kelly, M.D.

All interested are cordially invited to attend.

National Blue Cross.—In the Bay Area, 99,095 men, women and children now budget hospital bills through voluntary Blue Cross Plan membership. They are part of the 16 million persons in the United States prepaying hospital bills through these non-profit, community-sponsored Blue Cross Plans.

New members enrolled on the average of 12,000 a day through places of employment, professional groups and farm and community organizations.

Doctor bill prepayment plans doubled from 11 to 22 in 1944. Seventeen states and two Canadian provinces are now served by Blue Cross Plans.

Los Angeles 1944 Grand Jury Takes Last Shot at General Hospital.—The Los Angeles county grand jury for 1944 yesterday bowed out of office, but not before it filed its final report in which it recommended something be done about the manner the Los Angeles County General Hospital conducted its financial business.

The 19 men and women, through William E. Beach, chariman of the jury's audit committee, recommended that:

1. The Board of Supervisors study the present operations of the $17,000,000 hospital, which employs 3,600

persons and operates on an annual budget of $6,500,000.

2. The hospital's policy of fixing rates for various services, billing patients and exemption of certain classes of patients should be reviewed by the county Board of Supervisors.

3. The hospital be made to follow recommendations in its accountings as specifically ordered by the county auditor.—Los Angeles *Daily News,* January 20.

Physicians' Federal Income Tax.—The *Journal of the American Medical Association* for February 10th on pages 338-341 prints valuable information concerning the physician's Federal income tax The article was prepared by the A.M.A. Bureau of Legal Medicine and Legislation. The attention of physicians who desire information concerning items such as tax rates and exemptions, gross and adjusted incomes, physicians in service, deductions for professional expenses, contributions to charitable organizations, and miscellaneous deductions, will find this article of special interest.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Seventy Doctors Have Been Killed In War Theaters

Chicago, Jan. 15.—(AP.)—*The Journal of the American Medical Association* disclosed in its current issue, 70 physicians were reported killed in action in war theaters in 1944 and 113 others died while in military service.

Of the group killed in action, the *Journal* stated, specific information is not available in most cases on the type of death, adding that a number of physicians who first were reported missing in action later have been given a presumptive date of death.

Theaters of operation designated in official reports as those where injuries resulting in death occurred are:

The Pacific area, 17; European area, 10; France, 12; Italy, five; North Africa, six; Atlantic area, three; Anzio beachhead, three; Normandy, two; Bougainville, Marshall Islands, Isle of Capri, Guam, Tarawa, Coral Sea, Savo Island and Sicily, each one.

One died en route from Tunisia to Sicily, the *Journal* said, while location was not mentioned in three obituaries.

Of the physicians who were killed in action, the *Journal* reported 26 died in the age group 25 and 29, 33 between 30 and 34, eight between 35 and 39, two between 40 and 44, and one between 45 and 49.

Of the 113 physicians who died while in military service, 20 deaths were caused by airplane accidents.—Sacramento *Bee,* January 15.

Two Million 4-F's Charged To Illiteracy

Illiterate Rejectees Are Included in the Four Million Rejectees Due to Physical and Mental Causes

Dr. John K. Norton of Columbia University said on January 29 that illiteracy alone has deprived America of a fighting force equivalent to the Russian Army now driving toward Berlin.

Norton testified at a hearing held by the Senate Committee on Education and Labor that "we have had to reject at least 2,000,000 4-F's—enough men to equal the army put on the current Russian offensive—because they were denied educational opportunity."

He said Southern States, with "substandard schools—and sometimes no schools—have thrown up such a large percentage of 4-F's that we have had to turn to other sections to find men.

"More youths from New York, Connecticut, Massachusetts, California and Illinois will be killed in this war than would have been had we had reasonable educational opportunity."

Senator J. William Fulbright (D., Ark.) commented that "this means our ablest men will be killed."

Assailing what he termed America's "educational slums," Norton said more than half of the country's school children are given "completely inadequate" schooling. He said the 1940 census listed nearly 3,000,000 adults who had never attended any school, more than 10,000,000 adults classified as "virtual illiterates," and nearly 2,000,000 children from the ages of 6 to 15 who were not attending any kind of school.

U. S. Battle Casualties

737,342 Is Toll; Losses in Army Reach 650,420

Washington, Feb. 2.—(AP.)—American battle casualties have zoomed to 737,342 since Pearl Harbor, rapidly nearing the toll of the Civil War, heretofore the Nation's costliest conflict.

The great bulk of dead, wounded, missing or captured by the enemy was reported by the Army. Announcement also was made that 5,100,000 of the 8,100,000 in the Army now are abroad.

Army and Navy Figures

Acting Secretary of War Patterson told his news conference that Army casualties, including those during most of the fighting in December, have reached 650,420. The Navy reported 86,922.

Civil War Figures

The figures included an aggregate of 154,565 killed, some 13,000 short of the number of Confederate and Union soldiers who died in battle during the war between the states. Including deaths from disease and other cause, total casualties of both sides have been estimated at anywhere from 800,000 to 1,000,000 in that conflict.

Disclosure that the Army troops remaining at home had dwindled to 3,000,000 came with Patterson's report that the Army had reached the bottom of the barrel in drawing urgently needed infantry replacements from the divisions in the United States.

Patterson said that the domestic units had been tapped for 500,000 replacements and that 10,000 men overseas are being shifted every month from noncombatant units to the infantry.

Replacement Sources

The 500,000 included, among others, 50,000 culled from the Army specialized training program, 80,000 shifted from the air and service forces and 90,000 who had volunteered to transfer into the infantry from other branches

Of the troops now in this country, the Army reported 1,000,000 are being trained as infantry replacements for overseas units, 1,000,000 are in training with tactical units which also will be sent overseas and 1,000,000 are in so-called housekeeping units composed of limited service men and those who have returned from overseas.

The armed forces listed this breakdown of the casualties:

Army—Killed, 121,676; wounded, 379,638; missing, 91,573; prisoners, 57,533.

Navy—Killed, 32,889; wounded, 39,807; missing, 9,750; prisoners, 4,476.

Patterson said 186,000 wounded men have recovered and been returned to duty.—San Francisco *Chronicle,* February 3.

Nurse Draft Issue

"Public Favors It"—Gallup

Princeton, N. J., Feb. 2.—President Roosevelt's proposal that nurses be drafted to serve with the Army and Navy finds substantial approval from the American public, judging by the results of a public opinion survey just completed.

Approximately three persons out of every four in the poll expressed approval of taking this drastic step to end the nursing deficiency in the armed forces. The President made his proposal in his annual message to Congress early last month.

The country's reaction was sounded by the Institute in the following poll:

"Do you approve or disapprove of the proposal now before Congress to draft nurses to serve with the Army and Navy?"

The vote is:

	Per Cent
Approve	73
Disapprove	19
No opinion	8

The Institute concurrently conducted another poll on the issue, using the so-called "open" type of question, namely: "What is your opinion of the proposal now before Congress to draft nurses to serve with the Army and Navy?" An analysis of the replies shows that 73 per cent indicated an attitude favorable to drafting nurses if volunteering proves inadequate. . . .—George Gallup, Director, American Institute of Public Opinion, in San Francisco *News*, February 2.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Vast Health Plan Favored

Federal, States Postwar Program Urged by Senate Group

Washington, January 3.—(AP)—A Senate subcommittee recommended today a vast national health program centered about postwar Federal-State construction of hospitals and health centers.

The group, headed by Senator Pepper, Democrat, Florida, also recommended:

1. Federal loans and grants to aid in providing sewer and water facilities and milk pasteurization plants in communities that lack them.

2. Fulltime public health departments in all communities as soon as needed personnel becomes available, with increased federal grants to State health departments.

3. Army consideration for increased induction and rehabilitation of men rejected because of mental and physical defects.

4. Preservation of Selective Service's medical records and appropriation of funds for study of them.

5. Immediate steps to provide more medical men with training in psychiatry "with a view to providing child guidance and mental hygiene clinics on a far-wider scale."

6. Federal scholarships or loans to assist qualified students—both men and women—desiring medical or dental education.

7. Federal funds be made available to the States for medical care of all recipients of public assistance.

In advancing these proposals, the group, appointed by the labor committee to study wartime health and education, made no estimate of cost. Members in addition to Pepper are Senators Thomas, Democrat, Utah; Tunnell, Democrat, Delaware; La Follette, Progressive, Wisconsin, and Wherry, Republican, Nebraska.

COMMITTEE ON SCIENTIFIC WORK

C.M.A. 1945 Annual Session

The requirements of the Office of Defense Transportation are as follows:

(1) Any convention or meeting must be less than 50 traveling persons in order to accomplish three things:

1. Avoid the use of public transportation, such as railroads.

2. Prevent crowding hotels with overnight guests.

3. Prevent throwing extra work upon hotel management through extra care of meeting rooms.

* * *

In order to accomplish the above ends, the California Medical Association is proceeding as follows regarding its meeting in Los Angeles on Sunday-Monday, May 6-7, 1945.

I. The only official delegates for whom the California Medical Association will be responsible will be General Officers and Delegates of Component County Societies, (not to exceed the number of 46 from counties outside of Los Angeles).

II. Meetings will be held, not in hotels, but in the Elks Temple, and the headquarters of the Los Angeles County Medical Association, (in order to avoid hotel service).

III. The Scientific programs will be carried through, but with Los Angeles members in charge of the meetings. In addition, C.M.A. members who are not resident in Los Angeles, will be permitted to have their papers read by title, so that the same will be eligible for consideration in the Official Journal, "California and Western Medicine." Or, a non-Los Angeles resident may ask some Los Angeles member to read his paper, through mutual arrangement that may be satisfactory to the Section Officers.

C.M.A. members in the Los Angeles area, who would be on the programs of the Scientific Sections and who do not live in the City of Los Angeles, will be requested to motor into Los Angeles for Sunday morning or afternoon, or Monday morning or afternoon, in order to avoid the use of public transportation.

74th Annual Session—C.M.A.

Present plans of the Council of the California Medical Association and of the C.M.A. Committee on Scientific Work contemplate an annual session of the California Medical Association in Los Angeles on Sunday-Monday, May 6-7, 1945, even though the attendance be largely confined to the Los Angeles area.

The letter which follows gives additional information concerning tentative plans.

* * *

(COPY)

California Medical Association

San Francisco, January 25, 1945.

Officers of all Scientific Sections of C.M.A., *Addressed.*

Dear Doctors:

Every Section Officer has received several letters from the C.M.A. Committee on Scientific Work, in re: section programs for this year's annual session, scheduled to be held in Los Angeles, Sunday-Monday, May 6-7, 1945.

Because of newspaper and other items regarding governmental transportation rules, etc., the following information is sent to each of you, as based on action taken by the C.M.A. Executive Committee.

1. The Annual Session will be held in Los Angeles, even though the *actual* attendance will be practically limited to members of the Los Angeles County Medical Association (a county society having some 3,000 members, which is larger than many state societies).

2. Section Officers should proceed with plans to secure papers from C.M.A. members representing other sections

of the State, even though the authors may not be able to attend the Annual Session *in persan.*

(Note. Such papers can be listed, "Read by Title," but can be actually read, if desired, by some section member living in Los Angeles.)

This plan will also give California and Western Medicine up-to-date papers, and such "Read by Title" papers will be eligible for publication in California and Western Medicine.

* * *

From the above, you will note that all Section Officers have the responsibility to proceed with the arrangement of their respective programs.

Because of the transportation and associated difficulties of this wartime period, the Officers of each Section may wish to re-check on essayists who are in the Los Angeles area, both in civilian practice or nearby hospital stations of Army or Navy camps and hospitals.

Cordially yours,

C.M.A. Committee on Scientific Work,
By George H. Kress, *Chairman*
(ex officio, Association Secretary)

COMMITTEE ON POSTGRADUATE ACTIVITIES

Fourteenth Midwinter Postgraduate Clinical Course of Research Study Club of Los Angeles

Four Hundred Eye, Ear, Nose and Throat Specialists Attend Conference

More than 400 eye, ear, nose and throat specialists from all over the country began assembling on January 22 for the fourteenth annual midwinter postgraduate clinical convention in ophthalmology and otolaryngology, which got under way at the Elks Temple, 607 South Parkview avenue, Los Angeles. The convention continued to Feb. 2.

Held under the auspices of the Research Club of Los Angeles, the conference was the nature of a post graduate study clinic embodying a free exchange of ideas and new clinical experience.

Listed as teachers were the following out-of-town doctors: John J. Shea, Memphis; Cecil S. O'Brien, Iowa City, Iowa; Hans Brunner, Chicago; Kenneth G. Swan, Portland, Ore.; Guy L. Boyden, Portland, Ore.; William Chrisp, Denver; Chauncey D. Leake, Galveston; Samuel Salinger, Chicago; Irving B. Lueck, Rochester, N. Y.; Scott N. Reger, Iowa City, Iowa; George N. Hosford, San Francisco; Meyer Wiener, Coronado, Cal., and Samuel A. Crooks, Loma Linda, Cal.

On Monday evening, January 22, the Los Angeles Society of Ophthalmology and Otalaryngology held its annual meeting and banquet at the Elks Club and welcomed the members and taeching staff of the Mid-Winter Course. In addition to Guest-Letcurers of the Mid-winter Course, President Lowell S. Goin and Secretary George H. Kress of the California Medical Association were called on to discuss current medical legislation.

COMMITTEE ON MEDICAL ECONOMICS

Gross and Net Incomes of Physicians

(copy)

American Medical Association
535 North Dearborn Street
Chicago, 10

January 29 1945.

My dear Doctor Kress:

Your letter of January 26 came to my desk a few minutes ago.

We have no late figures pertaining to physicians' incomes. Some years ago we undertook what I believe to be the most intensive and comprehensive survey that has ever yet been undertaken but when it was all done some of us had grave doubts as to the accuracy of the figures reached. Instead of using the methods usually employed in making such surveys we made a very earnest effort to secure information from many thousands of doctors rather than from a very few hundreds or a very few thousands. It was found that it was exceedingly difficult to secure information from men in the lower income groups and even more difficult to secure dependable information from the men in the highest income groups. Responses received from some states were very meager and from other states much more numerous than had been expected. It is my purely personal opinion that many individuals kept exceedingly poor records and that the estimates of their own incomes were little more than guesses, that being especially true with respect to net incomes. Even so, the figures that were developed as the result of our survey were rather closely in agreement with figures compiled by the Committee on the Costs of Medical Care.

I doubt very much that it is advisable to utilize any figures that have been recently compiled for the purpose of estimating the average incomes either gross or net. There are now some 60,000 physicians on active duty with the military forces and with other governmental agencies that are immediately concerned with medical service as an important part of the war effort. That means, of course, that the number of physicians available for civilian service is relatively small as compared to the number that would be available in normal times. Naturally, it is, of course, inevitable that individual incomes in 1943 would be higher than in normal times and the result is that any picture that might be drawn on the basis of present conditions would be altogether abnormal and would not mean anything except that physicians now engaged in civilian practice are enjoying larger incomes than ever before.

However, all this may be, I shall make immediate effort to secure for you available information concerning our own survey and I shall forward it to you at the earliest possible time.

With all good wishes, I am,

Very truly yours,
(Signed) Olin West.

* * *

(copy)

Western Union Telegram
Chicago, January 29, 1945.

Dr. George H. Kress,
450 Sutter Street,
San Francisco.

American Medical Association survey of 1928, median gross income all physicians was $7,431. Private practitioners $8,090 median net, all physicians same year $4,555.

Private practitioners, $4,938 Committee on the costs of medical care survey of 1929. Median gross income all physicians was $7,026. Private practitioners $7,662. Median net all physicians, $4,200.

Private practitioners $4,100 Michigan State Medical Society survey, 1931. Median gross all physicians $5,637. Median net all physicians $3,264.

California Medical Association survey, median net income $5,000 to $5,999 in 1929; $3,000 to $3,999 in 1933.

State Medical Society of Wisconsin in 1930 indicated twenty-six and three-tenths per cent physicians net in-

come of less than $2,000; fifty-seven and nine-tenths per cent net income of less than $4,000; and thirty-two per cent over $5,000.

In Utah on basis of small survey, average gross income in 1928, $9,943 and in 1933, $5,661; average gross income in 1928, $9,943 and in 1933, $5,661; and approximately same figures for Colorado.

Olin West.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

San Francisco Health Survey

Closing of San Francisco's emergency hospitals will be recommended by the two doctors of the American Public Health Association who have been hired by the city to survey the Health Department.

Their report will criticize Health Director Geiger for carrying too much of the burden of his department alone, it was learned yesterday, and will recommend scrapping of a closed shop agreement giving staffs of the two university hospitals exclusive rights to work in San Francisco Hospital.

The two doctors, Dr. Carl Buck and Dr. George Palmer, reportedly believe it would be more economical for the city to pay for the treating of emergency patients at private hospitals than to maintain staffs constantly at the five emergency hospitals.

Their criticism of Dr. Geiger will be that he is too conscientious, and that his failure to delegate more authority interferes with the efficiency of the Health Department. Dr. Geiger is known to keep a close personal watch on all institutions and departments under him, making many of the decisions which could be delegated to assistants.

University of California Hospital and Stanford Hospital have had exclusive charge of all county patients at San Francisco Hospital for many years.

A group of psychiatrists recently requested that two wards at the hospital be opened up to private physicians and doctors for the care of mental cases, and the Supervisors have the request under consideration.

Dr. Geiger said the present set-up was ideal, as far as the city is concerned, and also was ideal for the training of young doctors by the universities.

The investigating doctors were hired by Chief Administrative Officer Thomas A. Brooks to make the survey.

Brooks said he did not feel anything was wrong with the Health Department, but believed "we are sometimes too close to the picture to see needed changes."

The doctors have been studying the department for three months and will file their report in a week or 10 days.—San Francisco *Chronicle*, January 27.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Salary Stabilization As It Affects Employees in Offices of Physicians and Surgeons

This is substantially the same article as appeared in the January, 1945, issue of the *Bulletin* of the San Francisco County Medical Society under the above title. It is reproduced in this column with some minor changes because the subject matter is of importance to every physician and surgeon in the State of California.

Wage and Salary Stabilization as instituted in October, 1942, by an amendment to the Emergency Price Control Act and the President's Executive Orders thereunder applied to all employers in the United States. Either the National War Labor Board or the Commissioner of Internal Revenue was vested with jurisdiction to regulate all wage and salary increases and decreases with the Commissioner being granted jurisdiction over all salaries in excess of $5,000, and those salaries of less than $5,000 paid to executive, administrative or professional employees. The National War Labor Board was given jurisdiction to control wage and salary increases or decreases in all other cases. By the terms of the President's Executive Order No. 9250, the National War Labor Board was authorized by general regulation to make such exemptions from the salary stabilization law in cases involving small total wage increases as it deemed necessary for the effective administration of salary stabilization. Under its General Order No. 4 the War Labor Board exempted from the operation of salary stabilization all wage adjustments made by employers who employed eight or less individuals. Under this exemption, until October 6, 1944, doctors employing eight or less individuals including nurses, anaesthetists, laboratory or x-ray technicians were free to raise or lower the salaries of their employees in most instances without consulting the War Labor Board, provided that no more than one increase per person per year was permitted.

On October 6, 1944, the National War Labor Board removed the exemption under General Order No. 4 to employers of eight or less employees who employ laboratory technicians, pharmacists, nurses, anaesthetists, x-ray technicians or physical therapists in Region 10 covering the States of California, Nevada and Arizona. The effect of the removal of this exemption subjects all doctors' offices in this area where any nurse, technician, pharmacist or physical therapist is employed to wage and salary stabilization. No doctor having this type of employee is permitted to increase the salary of any employee in his office (with the exception of another physician or surgeon) or to decrease the salary below the highest rate paid employees between January 1, 1942, and September 15, 1942, without first securing the approval of the National War Labor Board, unless an increase falls within one of the special instances wherein the War Labor Board has by its regulations authorized increases without prior approval. General Order No. 5 of the National War Labor Board reads in part as follows: "Subject to the requirements of General Order No. 31, Wage adjustments may be made in the rates of individual employees, without approval of the National War Labor Board, if they are incident to the application of the terms of a wage agreement which existed previous to or has been approved since October 3, 1942, or incident to an established or approved wage rate schedule covering the work assignments of employees and are made as a result of:

(a) Individual promotions or reclassifications;

(b) Individual merit increases within established rate ranges;

(c) Operation of an established plan of wage increases based upon length of service;

(d) Increased productivity under piece-work or incentive plans;

(e) Operation of an apprentice or trainee system."

In any other case where a physician wishes to decrease or increase the salary of any of his employees, he

† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

should obtain from the National War Labor Board its Form No. 10, and file his application for approval of the proposed increase or decrease on this form with the War Labor Board office for his community, or such office as the Board may have designated. There are severe penalties for any violation of the Salary Stabilization regulations, including the power of The Commissioner of Internal Revenue to disallow as a deduction for income tax purposes all compensation paid to any employee who receives any payment made in contravention of the salary stabilization regulations.

Salary and Wage Stabilization also governs the payment of bonuses. Under War Labor Board regulations a bonus paid in a fixed amount (not based on any percentage of salary) may not be paid in an amount larger than the bonus paid for the same position at the close of the taxable year immediately preceding the current year. If the bonus is computed on a percentage basis, such as 5 per cent of the yearly salary, the percentage cannot be increased over the percentage used in the year immediately preceding. The employer must also have an established practice of customarily paying bonuses. In the event a bonus in a larger amount or based on a larger percentage is proposed, an application for approval must be filed with the War Labor Board. The only exception to this rule is that a $25 Christmas or year-end bonus was authorized to be paid without approval in 1944 even though the employer has never paid bonuses or did not pay one the previous year. In the case of new employees, they may be paid a year-end bonus without approval equal to that payable to employees doing the same or similar jobs.

LETTERS†

Concerning Relative Value of a Physician's and a Taxi Driver's Services: Re California Industrial Accident Commission:

(COPY)

Claremont, California, January 30, 1945.

Los Angeles County Medical Association,
1925 Wilshire Blvd.,
Los Angeles, Calif.
Dear Sirs:

Re: Mrs. Z————, insured by California State Compensation Insurance Fund:

An interesting fact has developed during the care of this patient which I believe should be brought to the attention of three agencies: you, the State Compensation Insurance Fund and the Industrial Accident Commission.

This patient injured her ankle so severely that she had to be hospitalized, but was not so badly hurt but that I could send her over in a local taxi. Much to my surprise, the taxi charged $2.00 for the trip. I had no recourse but to approve the bill.

However, the point of the matter is that the Industrial Accident Commission allows me $1.75 for a hospital call and does not allow anything extra for mileage from Claremont to the hospital—yet a taxi company is allowed to charge $2.00 for merely transporting the patient and rendering no additional service.

Something is wrong with the rates when professional knowledge is worth less than a taxi fare.

Yours sincerely,
(Signed) MORRILL L. ILSLEY, M. D.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Rights of Military Colleagues to Practice in California:

(COPY)

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

Sacramento 14, California, January 29, 1945.

Secretary, County Medical Society, *Addressed.*
Dear Doctor:

Doctor George H. Kress, Secretary of the California Medical Association has forwarded us a copy of his letter of January 25th relative to the right of Doctors in the Army to practice on civilians.

It has been ruled by the Office of the Attorney General of California that a medical officer not holding a license in the State of California can only practice within the confines of Army reservations or government hospitals, and such officers are not permitted to practice on the civilian population outside of such limitations.

Yours very truly,
FREDERICK N. SCATENA, M. D.
Secretary-Treasurer

Concerning Inclusion of Osteopathic Physician's Name in Listing of Doctor of Medicines, in Telephone Directory:

(COPY)

San Francisco 4, January 27, 1945.

California Medical Association, *Addressed.*
Attention: George H. Kress, M.D., Secretary.
Dear Doctor:

I have your letter of January 26th with reference to the listing of an osteopathic physician and surgeon in the telephone directory of the city of ————, in the classified column under "physicians and surgeons, M.D."

It is my opinion that the representative of the Telephone Company who states they have no authority to take Dr. ———'s name out of this column unless the request is made by Dr. ——— himself is correct. The Telephone Company could not assume the burden of determining that each individual listing himself in the directory had held the degree of Doctor of Medicine when a listing in that column was requested.

Business and Profession Code, Section 2430 provides as follows:

"False assumption of degree or title: False statement on application. Any person is guilty of a misdemeanor who, individually or in a representative or any other capacity, assumes any degree or title not conferred upon him in the manner and by the authority recognized in this chapter with intent to represent falsely that he has received such degree or title or who, individually or in a representative or any other capacity, willfully makes any false statement on any application for examination, license or registration under this chapter."

It would seem that this would be a matter for the Board of Medical Examiners to take up with Dr. ——— as he is apparently violating this section.

Very truly yours,
(Signed) HARTLEY F. PEART
Legal Counsel, C.M.A.

111 Sutter Street.

Concerning Disciplinary Procedures on Patient's Complaint to a County Medical Society:

(COPY)

Dear Dr. ————:

We have examined your letter of October 30, 1944, with enclosed patient's statement and have examined the ———— County Medical Society constitution and by-laws.

As to the proper method of submitting a patient's complaint to the Society, we find the following:

1. Chapter V, Section 1 (a) of your by-laws adopts the disciplinary procedure set out in Chapter II, Section 3 of the by-laws of the C.M.A.

2. Section 1 (b) of said chapter in your by-laws provides that charges may be referred either by a member of the Society or by the Committee on Professional Relations. In this instance, I assume that no specific member could prefer the charges, and, therefore, formal charges would have to be filed with the Council by the Committee on Professional Relations.

3. Chapter IX, Section 4 (f) defines the duties of said Committee requiring it to "receive and investigate all complaints against any member of this Society accused of an act or omission subject to discipline according to Article IV of the constitution of the Society and may prefer formal charges on its own motion of any such act or omission when it deems such action justified." This reference to "Article IV" apparently is a misprint and is intended to refer to Section 4 of Article II of the constitution. As Section 4 governs all disciplinary action, the Committee on Professional Relations has authority under your by-laws to hear the complaint by a patient and then to file formal charges against the physician involved with the Council as it deems such action justified.

4. Section 4 (f) of Chapter IX of your by-laws also provides that acts and proceedings of the Committee on Professional Relations shall be secret and confidential until it files formal charges.

In view of the foregoing, I suggest that the proper procedure to be followed in this case would be first, to refer the patient's complaint to the Committee on Professional Relations which could consider the matter, interview the complaining patient and, perhaps, the patient's friend who may also have cause of complaint on account of the treatment of her son. If the Committee on Professional Relations determines there are grounds for filing charges, it should then file formal charges with the Council of the ———— County Medical Society following the procedure set out in Chapter II, Section 3 of the C.M.A. by-laws.

If the Committee on Professional Relations should determine to file formal charges with the Council of the Society, we will be glad to advise you further, if desired, on any questions which may arise under the procedure set out in the C.M.A. by-laws.

We are returning herewith your copy of the ———— County Medical Society constitution and by-laws.

Very truly yours,
(Signed) Hartley F. Peart.

Concerning Item Regarding Late Dr. Paul Tatsuguchi:

(copy)

College of Medical Evangelists
Clinical Division
White Memorial Hospital
Los Angeles, November 24, 1944.

George H. Kress, M.D., Editor, *Addressed.*

Dear Dr. Kress:

I am very slow in answering your letter of November 6, regarding the article which was published in California and Western Medicine, for October (p. 210), regarding the death of Dr. Paul Tatsuguchi at Attu. I have heard and have read a number of reports regarding this man, and I suppose that if we ever know the truth we may have to wait until the close of the war. I understand that some of the information in his diary was made public, but that much of the information has been withheld by the military.

At any rate, I am enclosing two articles which have been published here, the first one is of September 15, 1943, and the other is in the Alumni Journal of November, 1943. It may be that the report in the California and Western Medicine is correct, but one or two of the boys who have investigated the situation at Attu apparently disagree with some of the opinions as published by the press.

While Tatsuguchi was a student with us he was very quiet and coöperative and otherwise a good student. A number of his classmates refused to think the worst of him and believed that to a greater or lesser extent he was a victim of circumstances because he was in Japan at the outset of the war. . . .

With best regards, I remain,

Sincerely yours,
(Signed) W. E. Macpherson, M.D., *President.*

Concerning Facilities for Plastic Surgery in Government Hospitals:

(copy)

The American Legion
Department of California
Service Department, Veterans Administration,
Fort Miley, San Francisco 21, California

Dear Dr. Kress:

Your recent communication addressed to the State Veterans Welfare Board regarding Plastic Surgery in Veterans' Hospitals has been referred to my attention for reply.

It has been our experience that in nearly every case where a veteran needed plastic surgery he was given this attention before he was discharged from the Armed Forces.

The Veterans Administration have the authority to do this type of surgery for veterans who require same after they are discharged from the Military Service and the provisions of their regulations are quite liberal which provides that if they do not have on their Staff qualified plastic surgeons at the time such surgery is needed the Managers have the authority to hire on a fee basis qualified doctors for such work.

If there is any other question at issue in this matter that I have not answered, please feel free to call upon me.

Yours very truly,
(Signed) Charles R. Farrington,
Department Service Officer.

Private Nurse Use in Civilian Cases Curbed.—Because of the urgent need for nurses in the armed forces, civilian employment of certain classes of private duty nurses will be restricted under joint action taken on January 19 by the California State Nurses' Association and the State Committee for the Procurement and Assignment of Nurses.

Coöperation Asked

Identical resolutions adopted by the two agencies called on professional nurse registries operated by local districts of the nurses' association to "no longer fill private duty calls with private duty nurses classified by the Procurement and Assignment Committee as available for military service or essential duty."

California hospitals and doctors were called upon to coöperate in the move, which, if effective, should result in larger numbers of private duty nurses either responding to the appeals of the Army and Navy, or replacing in hospitals and other essential institutions nurses who have heeded the call to military service.

Private duty nursing needs of the civilian population, in this event, would be met by nurses ineligible for military duty, or by older nurses.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 2, February, 1920

EXCERPTS FROM EDITORIAL NOTES

Announcement.—The meeting of the Medical Society of the State of California, which was to be held at Del Monte, May 11, 12, 13, [1920] this year, has been transferred to Santa Barbara on the same dates. This was necessitated through the discovery that the Hotel Del Monte, which is the only caravansary capable of accommodating a large number of members, was unable to give us the dates assigned by our By-Laws. . . .

State Bureau of Child Hygiene.—The Bureau of Child Hygiene of the State Board of Health became an entity following the passage of a law at the last legislative, but the director of this bureau was not appointed until the State Civil Service Commission certified physicians who had passed an examination. . . .

California's Mineral Springs.—Of all therapeutic methods in use by the medical profession few, doubtless, can claim the antiquity, and unreserved commendation of immemorial use, so thoroughly as baths and the use of mineral springs both internally and externally. . . .

A recent bulletin of the University of Southern California is devoted to a most readable article by Professor G. E. Bailey on some hot springs of Southern California. Being a geologist, Professor Bailey describes with authority the natural resources of the state in mineral springs. . . .

Annual Meeting of the League of Public Health.—The third annual meeting of the League for the Conservation of Public Health was held in the Blue Room of the St. Francis Hotel, December 29. A complete review of the comprehensive work of the League was given in a report by Dr. Charles D. McGettigan, Chairman of the Executive Committee. . . .

From this report of the Executive Committee, we find that representatives of the League have been very busy during the past year, as they have traveled more than 50,000 miles through California in advancing the purposes to which the League is dedicated. That there was no lost motion, and that the good seed that was sown on the ground covered was growing sturdily was evidenced by abundant facts. . . .

It is not only the medical profession, which has too long endured the heavy handicap imposed by misfit methods of poor hospitals, that is welcoming the work of the League, but Chambers of Commerce and business organizations in several communities have enlisted the services of the League to develop hospital sentiment and make proposed new hospitals community service centers.

Another worthy enterprise of the League that is of interest not only to all the ethical members of the medical profession but to all the people of the State, is the

(Continued from Front Advertising Section, on Page 26)

† This column, compiled by the undersigned, strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

The date of the next meeting of the Board has been changed from March 5-8 as originally advertised to February 27-March 2. The place of meeting will be the Elks Club, Los Angeles. This was necessitated by circumstances over which the Board has no control. Every effort is being made to notify all applicants and others concerned as to this change of meeting date.

* * *

The number of applicants for reciprocity from other states of the United States and from the various military services is still far above normal and the Board has increased the number of oral examinations in an effort to meet the situation.

News

"Proposed legislation making important changes in the procedure of State administrative boards and bureaus has been given final approval by the State judicial council and will be introduced at the January session of the legislature, it was announced yesterday by Chief Justice Phil S. Gibson, judicial council chairman. Judge Gibson declared that the right of the individual to appeal to the courts from the rulings of these agencies will be preserved, 'simplified and clarified.' However, he said, the proposed amendments 'will also direct the courts to consider the public interest involved before restraining the effect of a board order while the case is pending in the courts.' The judicial council undertook its inquiry into administrative agency procedure at the request of the 1943 legislature. Its major recommendations, according to Judge Gibson, include: Substitution of a department of administrative procedure in place of the present department of professional and vocational standards, and giving its continuing responsibility to improve the operation of all State boards and commissions." (San Francisco *Examiner,* December 12, 1944.)

"Attorney General Kenny ruled yesterday that service medical officers not licensed in California may treat civilian visitors in national parks if a civilian doctor is not employed. The opinion was sought by the Board of Medical Examiners which questioned whether a Navy doctor stationed at Yosemite National Park for the benefit of servicemen that were quartered there could serve civilians." (San Francisco *News,* December 12, 1944.)

"Convicted of what the judge termed a technical violation of the law through sale of sodium pentobarbitol, Lyle Daniel Potter of the Medical Specialties Co. at 2428 West Sixth Street, was today granted immediate probation by Municipal Judge C. Newell Carns and a $15 fine. Attorney Everett Leighton, representing Potter, charged entrapment, claiming that a deputy sheriff, Robert G. Johnston, posed as a physician in buying the

(Continued in Back Advertising Section, on Page 42)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the secretary of the Board.

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

more miscarriages, particularly in the early periods of pregnancy. Beitler (1914) for example, estimated that 23.05 per cent of all births reported in the State of Maryland the previous year, were attended by midwives, only a little over half of whom were licensed. According to Beitler, 58.90 of the births among negroes and 15.57 of those among whites were attended by midwives. . . .

From an Article on "The Problem of Uterine Cancer," by Frank W. Lynch, M.D., San Francisco.—During the last few years, there has been attracted to the Woman's Clinic of the University of California Hospital—in large part because of our work with radium—an ever increasing number of cases of uterine cancer. No one, I am certain, could study the data offered by this mass of material without concluding very definitely that the general profession is doing little to improve the cancer situation, and that this disease in the hands of men doing surgery is quite as hopeless as it was years ago when MacMonagle reported his series of 481 hysterectomies for uterine cancer with only two ultimate cures, and when Baldy confessed that he had never cured a case by any form of treatment. . . .

From an Article on "Refinement of Colorimetric Methods with Special Reference to Indigo Carmine as a Functional Test," by George G. Reinle, M.D., Visiting Urologist, Samuel Merritt Hospital, and E. Spence DePuy, M.D., Associate Urologist, Samuel Merritt Hospital.—Accepted as probably the most valuable single test of Renal function, Phenolsulphonephthalein as

(Continued on Page 36)



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acceptable to the United States Public Health Service for the new rapid treatment of syphilis (August 31, 1944) is Dichlorophenarsine Hydrochloride, U. S. P. This newest anti-luetic is made available by E. R. Squibb & Sons as

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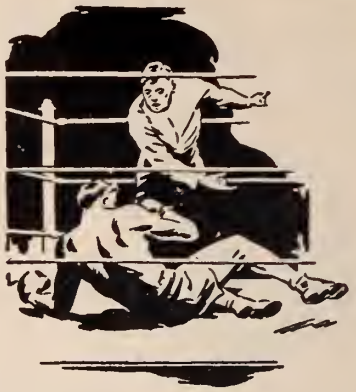
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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

proposed by Rountree and Geraghty[1] has won the deservedly high place it holds. With others we have found it to have every particle of value claimed for it, nor is it any part of our purpose to detract from its worth. Phthalein does, however, have the misfortune to be unserviceable in the presence of hematuria. This shortcoming is not due to any weakness of the dye as a test, but is inherent in the limitations of colorimetric methods. . . .

Excerpts from Correspondence: The Matter of Pay for Medical Service.

San Francisco.

To the Editor: An article appears in your issue of January, 1920, that seems to me to present a wrong point of view regarding the attitude of the physician toward his work; and while this point of view may appeal to a few members of the profession, I can not believe that it does to the great majority. . . .

It has been handed down by our fathers in medicine and it is as true today as it ever was, that the first and highest motive of the physician is service; that his constant desire, inspiring all his daily work, must be the relief of suffering and distress, as he has been trained to do; and to do it for the sake of doing it, not for what it will bring him in dollars and cents. . . .

A fair competency all may expect, enough for all the needs of life; but even if the doctor dies poor as regards this world's goods, the one who has been faithful to his ideals leaves behind him a good name that enriches his posterity more than any other heritage.

WM. FITCH CHENEY.

Shreve Bldg., San Francisco, Jan. 10, 1920.

(Continued on Page 37)



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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

Eddyism, Indians and Malaria.

To the Editor: Apropos of your comments on Mr. Ross' assertions—where he says that the American Indian lived by swamps and other breeding places of germs in blissful ignorance of their reputed deadliness, and hence with complete immunity from their attacks—I wish to state that I dispute both his propositions. . . .

The Indian was first, in my opinion, to discover the deadly effects of the malarial mosquito long before the white man discovered it.

In the winter season he camped with his people along the water courses—but as soon as the season of the malarial bearing mosquito arrived he would hie away to the dry and arid plains on his annual hunting expedition, and thus avoid the mosquito and the results of his activity.

All this was changed when the Government took him under control. . . .

Yours very truly,

FORDYCE GRINNELL,

Jan. 9, 1920. Pasadena.

Excerpts from County Society Proceedings: Los Angeles County.—Los Angeles County Medical Association, Friday Morning Club, December 4, 8 p.m., in Joint Meeting with the Southern California Medical Society. . . .

Dr. Walter V. Brem, the newly elected President, then was escorted to the chair.

Dr. Karl F. Meyer, of San Francisco, spoke on "The Bacteriological Contents of Milk and Its Relation to Health and Disease." He stated among other things that pasteurization does not destroy the vitamins or enzymes of the milk and that certified milk is not free of germs; that they are due to poor help who change so often that only the sick ones can be visited, that it would be better in all cases to Pasteurize the milk. He called attention to the fact that commercial dairies are getting better so that there is less use for certified milk. . . .

Address by Governor Stephens:

Denunciation of the "Reds" in this State was the keynote of an address by Governor W. D. Stephens, the guest of honor at the dinner tendered to returned members of Los Angeles County Medical Association at the Hotel Alexandria, December 10. Three hundred and

(Continued on Page 40)



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Medical Directors, Pasadena, California

TWENTY-FIVE YEARS AGO

(Continued from Page 36)

fifty diners applauded the Governor.

The Governor was introduced by Dr. W. W. Beckett, the toastmaster.

It was announced at the dinner that 319 of the members of the Association saw service in the war. . . .

Excerpt from Hospital Service Department: "The Model Community Hospital," by W. E. Musgrave, M.D., San Francisco.—Perhaps the best "follow up" of the more or less general discussion started in these columns last month is to submit a skeleton outline of a Model Community Service Hospital.

In subsequent notes it will be advisable to discuss some of the "thousand and one" problems inherent in the operation of this or any other organization anywhere, as well as some of the special modifications necessary to adjust the model to meet special conditions in special communities, with their great variation in available assets, peculiarities and needs. . . .

Menninger Sanitarium Reorganization.—An expansion program entailing expenditures of more than 1¼ million dollars was tentatively outlined Thursday at a special meeting of stockholders of the Menninger Sanitarium corporation when they approved a resolution to dissolve the corporation as of next June 30 and to transfer its assets to the Menninger Foundation. . . .

Treatment of a larger number of patients, both adults and children, without regard to their financial status, will

(Continued on Page 42)

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 102)

drug with marked money." (Los Angeles *Herald & Express*, December 8. 1944.)

(Press Dispatch—Folsom)—"Appointment of a resident physician for Folsom State Prison was announced today by Associate Warden Robert A. Heinze. Taking the post, which has been vacant for several years, is Dr. Orvall Smiley resident physician for the Pacific Gas and Electric Company's Big Bend (Calif.) project, and formerly of Cleveland, Ohio. Doctor Smiley will take over medical work now being done part time by two private practitioners, Dr. Paul De Witt Barnes of Loomis, California, and Dr. J. F. McAnally of Roseville." (San Francisco *Examiner*, December 29, 1944.)

"In temporary hospitals located only a few thousand yards behind the front lines, highly skilled medical officers of the U. S. Army daily are saving the lives of American soldiers. At such forward surgeries, tents usually are the only shelter, and packing crates often are used to support stretchers or improvised operating tables. Water must be heated over small stoves for the bathing of soldier patients. Although the forward hospitals often are within range of enemy guns, surgical teams work on so long as there are casualties who require treatment. As proof of the success of their efforts, 97 per cent of the wounded treated in this war have survived. Medical officers are to be found wherever American fighting men are stationed. They fly with the airborne troops, jump with the paratroopers, and land on enemy held beachheads with amphibious forces. The medical officers, Army nurses and enlisted personnel of the Medical Department work courageously and long to care for American soldiers. But many more medical officers and Army nurses are needed to assure our fighting men the finest possible care." (Lomita, Calif., *News*, December 7, 1944.)

MENNINGER SANITARIUM

(Continued from Page 40)

be a major aim of the foundation, for which a psychiatric hospital unit costing $750,000 is contemplated. . . .

Estimates for postgraduate education, including training for young psychiatrists, physicians returning from military service, nurses, teachers and others, were placed at $105,000; for research, $149,000; for scholarships for promising children, $30,000, and for publication, $5,000.

An urgent need for psychiatrists and psychiatric treatment for mentally ill war veterans returning at the rate

(Continued on Page 48)

For the symptomatic relief of sinusitis



In relieving the discomfort which almost invariably accompanies acute sinusitis, the striking success of Benzedrine Inhaler, N.N.R., is as logical as it is gratifying:—

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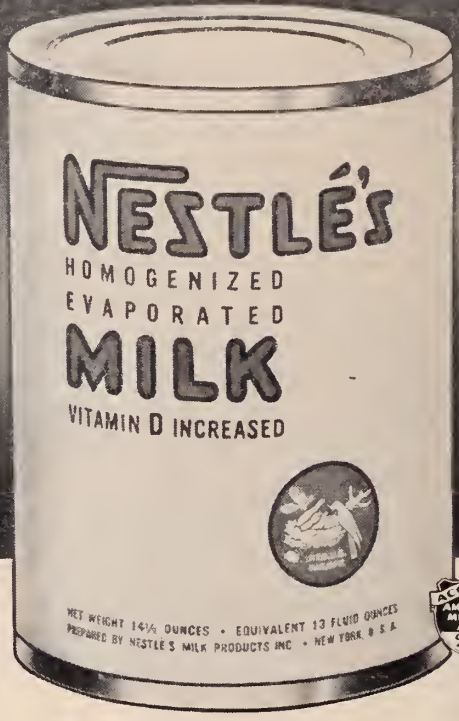
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BOOK REVIEWS

(Continued from Front Advertising Section, Page 26)

A National Health Service. Ministry of Health, Department of Health for Scotland. Presented by the Minister of Health and the Secretary of State for Scotland to Parliament by Command of His Majesty, February, 1944. Paper. Price, $.75. Pp. 85. American edition reproduced photographically from the English edition and published by arrangement with His Majesty's Stationery Office. New York: The MacMillan Company, 1944.

The Government of Scotland has announced that they intend to establish a comprehensive health service for everybody in their country. They want to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or on any other factor irrelevant to the real need—the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens.

The decision to establish the new service applies, of course, to Scotland as well as to England and Wales and the present Paper is concerned with both countries.

The special purpose of the Paper is to examine the subject generally, to show what is meant by a comprehensive service, and how it fits with what has been done in the past or is being done in the present, and so help people to look at the matter for themselves. The proposals made in the Paper (and summarized at the end)

(Continued on Page 48)

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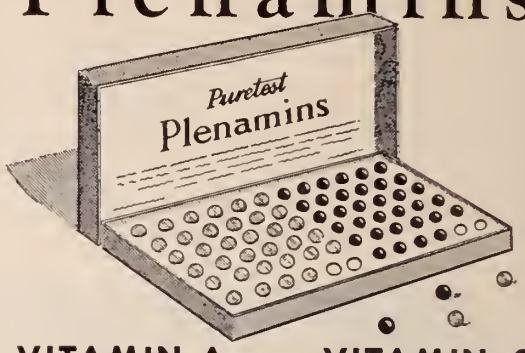
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BOOK REVIEWS

(Continued from Page 46)

represent what the Government believes to be the best means of bringing the service into effective operation. The Government wants these proposals to be freely examined and discussed. It is stated that the Government will welcome constructive criticism of them, in the hope that the legislative proposals which they will be submitting to Parliament may follow quickly and may be largely agreed.

MENNINGER SANITARIUM

(Continued from Page 42)

of 1,000 a day was reported in a brochure published in connection with the expansion of the Foundation. Emphasis was also placed on the necessity of making the same treatment available to a civilian population which has heretofore found it beyond its means. . . .

Formally organized in 1941, the Foundation has as its members a group seeking to assist in the advancement of psychiatry. Its activities in its three years of existence have included a dozen research and educational projects, construction of a modern research building with laboratories, classrooms and offices and the receiving of contributions from four foundations and from individuals.

Development of shorter and more effective methods of psychotherapy has been a major research project to meet what was described as a critical situation. Teaching of psychiatry both as a specialty and as an adjunct to general practice and creation of a loan fund to assist young physicians in financing their psychiatric education are parts of the educational program. . . .

BOMBING MISSION (medical version)



TARGET FOR TODAY...not Japs, but *rats*...mosquitoes...flies...disease-carrying insects and vermin that infest the steaming jungles of the Pacific.



For this is a *bombing mission in white!* The "bombs" are loaded not with T.N.T., but more likely with D.D.T. which, sprayed from the air, seeks out and kills the adult mosquito and fly.

Yes, with D.D.T., with the aerosol bomb and countless other new developments in sanitation and disease control, the soldiers of medical science are proving themselves fighting men through and through. And, like so many other fighting men, they find pleasure and cheer in a few moments relaxation with a cigarette. Probably a Camel for, according to actual sales records, Camels are the favorite with smokers in *all* the services.

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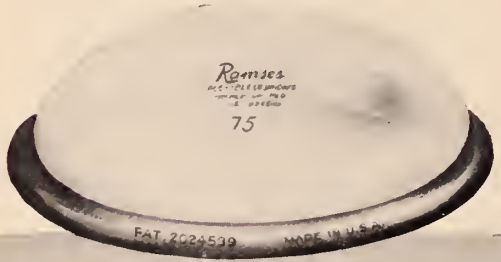
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It Can Happen Here



Example of severe rickets in a sunny clime.

LEST WE FORGET—we who are of the vitamin D era—severe rickets is not yet eradicated, and moderate and mild rickets are still prevalent. Here is a white child, supposedly well fed, if judged by weight alone, a farm child apparently living out of doors a good deal. This boy was reared in a state having a latitude between 37° and 42°, where the average amount of fall and winter sunshine is *equal to that in the major portion of the United States*. And yet such stigmata of rickets as *genu varum* and the quadratic head are plain evidence that rickets does occur under these conditions.

How much more likely, then, that rickets will develop among city-bred children who live under a smokepall for a large part of each year. True, vitamin D is more or less routinely prescribed nowadays for infants. But is the antiricketic routinely administered in the home? Does the child refuse it? Is it given in some unstandardized form, purchased from a false sense of economy because the physician did not specify the kind?

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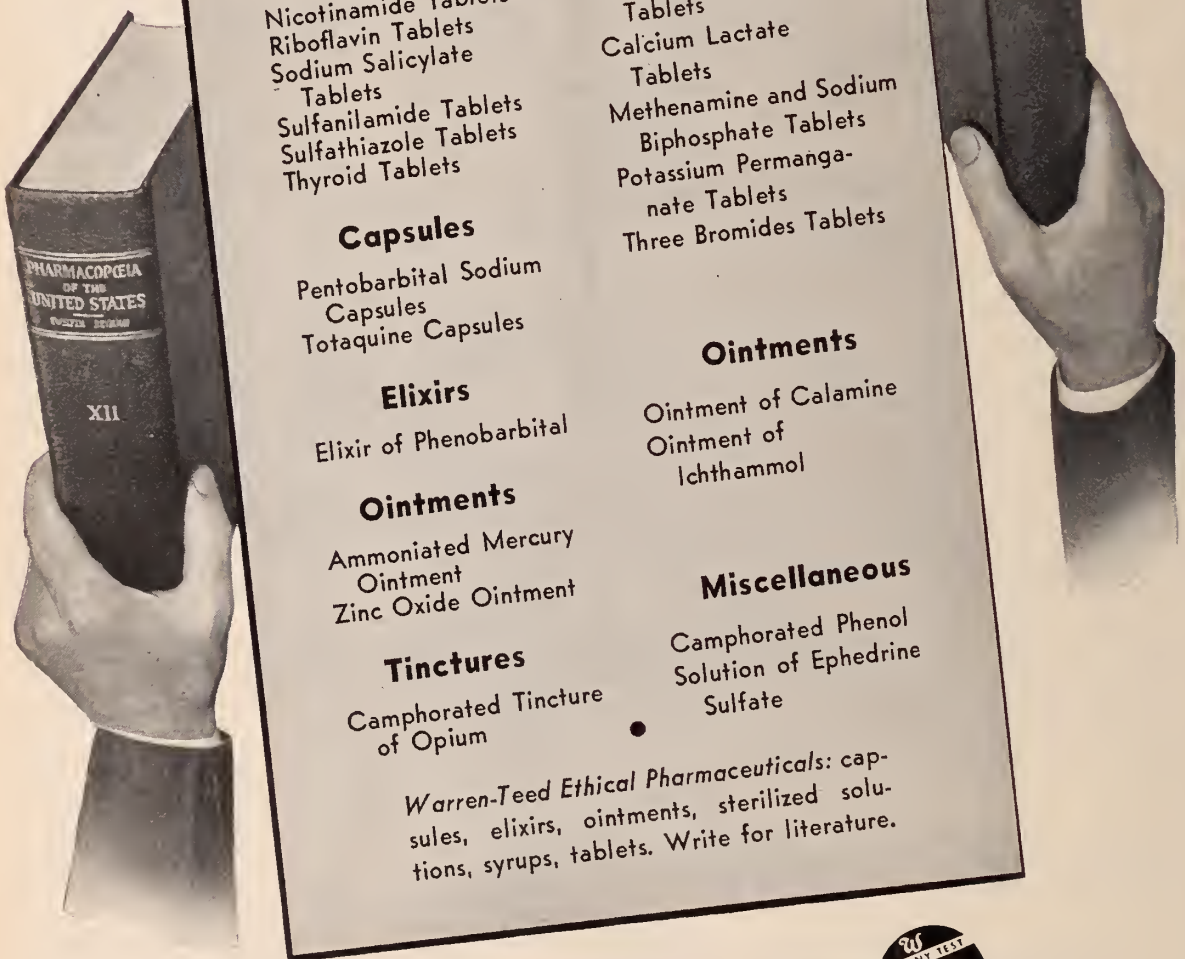
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BOOK REVIEWS

BOOKS RECEIVED

The Abortion Problem. Proceedings of the Conference Held Under the Auspices of the National Committee on Maternal Health, Inc., at the New York Academy of Medicine, June 19th and 20th, 1942. Howard C. Taylor, Jr., M.D., Conference Chairman. Cloth. Pp. 182. Baltimore: The Williams & Wilkins Company, 1944.

Modern Methods of Amputation. By Edmundo Vasconvelos, Professor, University of Sao Paulo, With an Introductory Survey of The Development of Amputation by Major General Norman T. Kirk, M.C., Surgeon General, U. S. Army. Cloth. Price, $10.00. Pp. 253, illustrated. New York: Philosophical Library, Inc., 1945.

Internal Medicine: Its Theory and Practice. In Contributions by American Authors. Edited by John H. Musser, B.S., M.D., F.A.C.P., Professor of Medicine in the Tulane University of Louisiana School of Melicine; Senior Visiting Physician to the Charity Hospital, New Orleans, Louisiana. Fourth Edition, Thoroughly Revised. Cloth. Price, $10.00. Pp. 1518, illustrated. Phildelphia: Lea & Febiger, 1945.

Casualty Work for Advanced First-Aid Students. By A. W. Macquarrie, M.C., Ch.B. (Edin.), Admiralty Surgeon and Agent Civil Defence Medical Officer Major, and Battalion Medical Officer, Home Guard. Cloth. Price, $1.80. Pp. 231, illustrated. Edinburgh: E. & S. Livingstone Ltd., 16-17 Teviot Place, 1944.

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(Continued on Page 10)

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Glenroy N. Pierce, M.D., San Francisco
Gerald L. Crenshaw, M.D., Oakland
Ina Gourley, M.D., Oakland

BOOKS RECEIVED

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Serological, Biochemical and Histological. By John A. Kolmer, M.S., M.D., Dr.P.J., Sc.D., LL.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry, Temple University; Director of the Research Institute of Cutaneous Medicine; Formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania, and Fred Boerner, V.M.D., Associate Professor of Clinical Bacteriology, Graduate School of Medicine and Assistant Professor of Bacteriology, School of Medicine, University of Pennsylvania; Bacteriologist, Graduate Hospital, Philadelphia. Fourth Edition. Cloth. Price, $10.00. Pp. 1017, illustrated. New York, London: D. Appleton-Century Company, Incorporated, 1945.

The 1944 Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price, $3.00. Pp. 432, illustrated. 304 South Dearborn Street, Chicago: The Year Book Publishers, 1945.

The Marihuana Problem in the City of New York. Sociological, Medical, Psychological and Pharmacological Studies by the Mayor's Committee on Marihuana. Cloth. Price, $2.50. Pp. 220. Lancaster, Pennsylvania: The Jacques Cattell Press, 1944.

BOOK REVIEWS

Samuel Brannan and The Golden Fleece. A Biography. By Reva Scott. Cloth. Price, $3.75. Pp. 462. New York: The Macmillan Company, 1944.

The author of this book is Reva Scott. Mrs. Scott was born in Spanish Fork, Utah, and educated at the University of Utah.

Mrs. Scott's first book, "Archer of Paradise," was a

(Continued on Page 16)

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apparently must be maintained at a level above normal in order to assure proper wound healing* and at least average resistance against infection.** The feeding of meat, therefore, in adequate amounts, as soon as it can be instituted, appears doubly advantageous: the protein content of meat is high and of highest biologic value; the human digestive tract appears well adapted for handling meat protein.**

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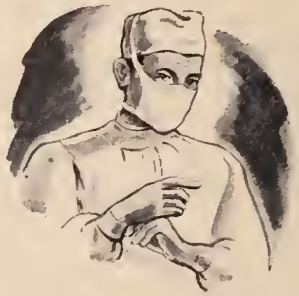
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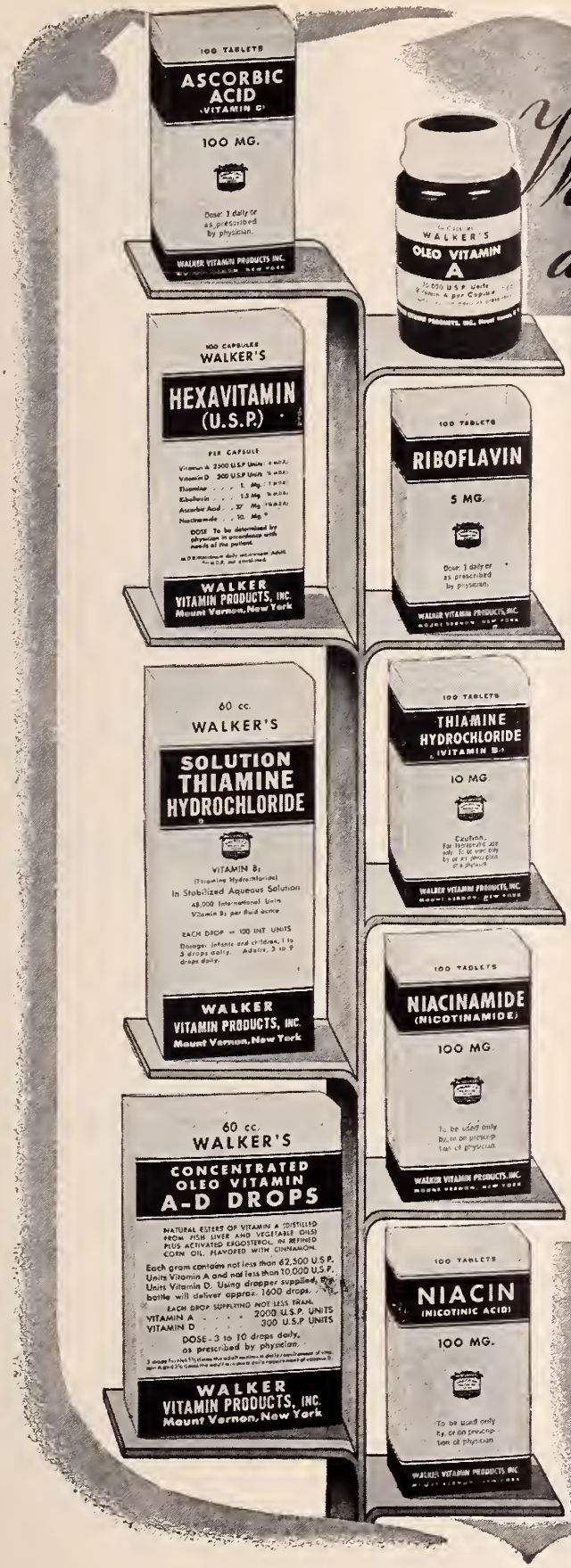
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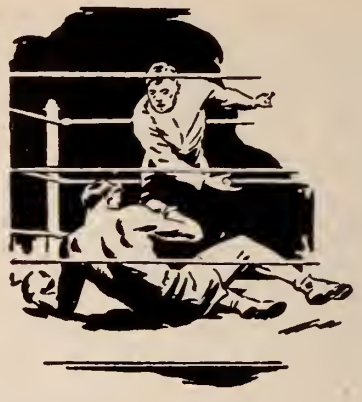
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BOOK REVIEWS

(Continued from Page 10)

biography of her great-grandfather, a member of the original Quorum of Twelve Apostles of the Mormon Church.

In the present volume, "Samuel Brannan and the Golden Fleece" (San Francisco's forgotten Jason), a fictionized biography of Samuel Brannan, two-wived Elder, then Apostate, of the Mormon Church, is all the bravura, all the rags-to-riches-to-rags drama of a robber baron of America's gold-rush days. It was he whom Brigham Young appointed, during the persecutions of 1845 and 1846, to lead a party of Saints by ship (the *Brooklyn*) around Cape Horn to Yerba Buena, which later became San Francisco. It was he who, in his own good time after he had built stores at Fort Sutter and other opportune sites, announced to America and to the rest of the world that gold had been discovered. Though his life was closely interwoven with the early history of California, and though he was a vivid and prominent personality of his day, he has since become a neglected, forgotten figure. His biography constitutes colorful history and Americana of unsurpassable interest.

The first Protestant church service ever held in San Francisco was called to order by Sam Brannan. He started the first school there; he published the first newspaper; he became California's wealthiest citizen; he helped finance the first railroad west of the Mississippi; he did more toward building San Francisco, Sacramento, and the State of California than any other person. He was an individual—a hell-roaring, courageous, six-foot-two, unscrupulous individual—the like of whom never lived before nor will again.

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Exclusive Prescription Pharmacy
Merced: Maze Drug Store
Modesto: Thorne's Prescription Pharmacy
Oakland: Peralta Hospital Pharmacy
Pasadena: Erikson & Quinn
Horton & Converse Prescription Pharmacy
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Sacramento: Pucci's Professional Pharmacy
Salinas: Holaday's Pharmacy
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TWENTY-FIVE YEARS AGO

(Continued from Text Page, 152)

Owing to the recognition of the importance of botulism as a type of food poisoning associated with canned foods, a sum of money has been raised by the olive growers and the canning industry for the intensive study of botulism in California. This investigation will be conducted in the laboratories of the Stanford University Medical School and the George W. Hooper Foundation of Medical Research of the University of California. It has the coöperation of the United States Public Health Service and the California State Board of Health. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

Excerpt from Hospital Service Department: From an Article on "The Organization and Management of Hospitals," by W. E. Musgrave, M.D., San Francisco.—There are four fundamental types of hospital organization and management:

(a) Municipal, City or County hospitals;
(b) Federal Government hospitals,
(c) Private hospitals,
(d) Corporations.

There are, of course, several varieties of each of these types; varieties in the efficiency, method of selection and duties of the governing bodies, as well as variations in the powers and duties of the chief executive officer. . . .

From an Article on "Comparison of the Action of Roentgen Rays and Radium," by Albert Soiland, M.D., Los Angeles.—In a former paper, the writer described the source and distribution of both radium and x-rays, and at this time would like to call attention to a comparison of the actinicity of radium and roentgen rays.

(Continued on Page 22)



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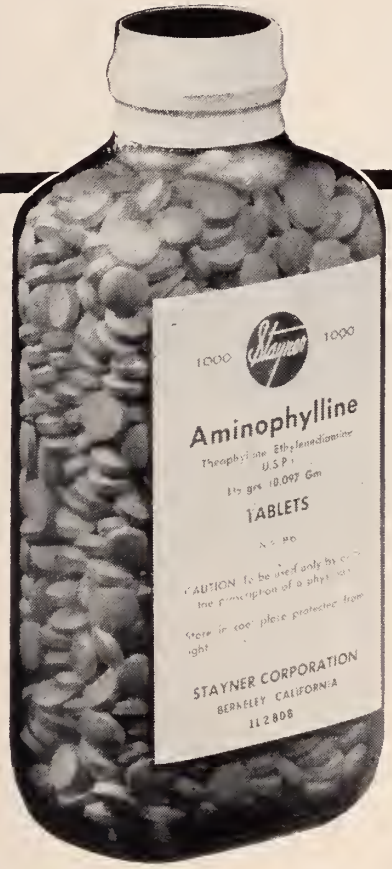
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*MacFarlane, M. G.: The Therapeutic Value of Gas-Gangrene Antitoxin, Brit.M.J., 2:636-640 (1943).

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Lecturer in Medicine, University of California Medical School San Francisco, California; Consultant in Allergic Diseases, Alameda County Hospital, Oakland, California

Octavo, 256 Pages. Cloth, $3.50

The new edition of this important work has been written with two objectives. It aims to stress the importance of food allergy in the production of allergic manifestations and to emphasize the value of the author's revised elimination diets for the determination of this condition. At the same time it discusses the other causes of clinical allergy and the latest methods for their diagnosis and control. The causes and methods of control of inhalant, infectant, injectant, and contactant allergies are discussed.

The author stresses the frequency of each type of allergy in the production of clinical manifestations, especially of bronchial and nasal allergy and of atopic dermatitis. Cutaneous, gastro-intestinal and ocular symptoms due to allergy each receive due attention. The emphasis on the susceptibility of the tissues of the body to allergic reactions indicates the value of this work to all physicians as well as to allergists. The work has been entirely reset to make possible the expansion of the text.

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Washington Square **LEA & FEBIGER** **Philadelphia 6, Pa.**

TWENTY-FIVE YEARS AGO

(Continued from Page 17)

In going over the literature devoted to the physics and therapeutics of radium, one is struck by a confusion of statements as to the penetration and distance traversed by the various radium rays. . . .

From an Article on "Refraction and Medicine," by Percy Sumner, M D., San Francisco.—So much has been published the last few years on focal infections that most physicians are fully alive to the dangers caused by these and usually institute a careful search for the offending member, when there is any obscurity as to the cause of the trouble of which the patient complains. Of course any movement of this sort is apt to be overdone and frequently one finds a patient minus teeth and tonsils and possibly other things that may still complain of indefinite and indeterminate discomforts.

It is for this class of patients that I am now taking the liberty of asking you as physicians if you have determined the condition of their eyes; have they errors of refraction that have either not been corrected at all or if treated then only superficially by an optician, or an oculist who does not appreciate the growing importance of thorough refraction in this age where the stress of life bears particularly hard on the nervous system? . . .

From an Article on "Aviation's Debt to Medicine," by Charles G. Stivers, M.D., (Los Angeles), Major, Medical Reserve Corps, U. S. Army.—Aviation presents two problems: one dealing with the mechanical, the plane and its equipment, and the other with the flier and his endowments and adaptations.

With the mechanical this paper has nothing to do, but deals with the choosing of the men who were to be trained as pilots and the care of them after they had learned to pilot planes.

This care of the pilot during the recent World War included the determination of the fitness of various fliers for all the different military activities. Men were selected for pursuit, for bombing, for observation—for high and low altitudes and for ground work only.

It is my contention that many valuable lives have been saved by this care and that aviation has been safeguarded by medical science. . . .

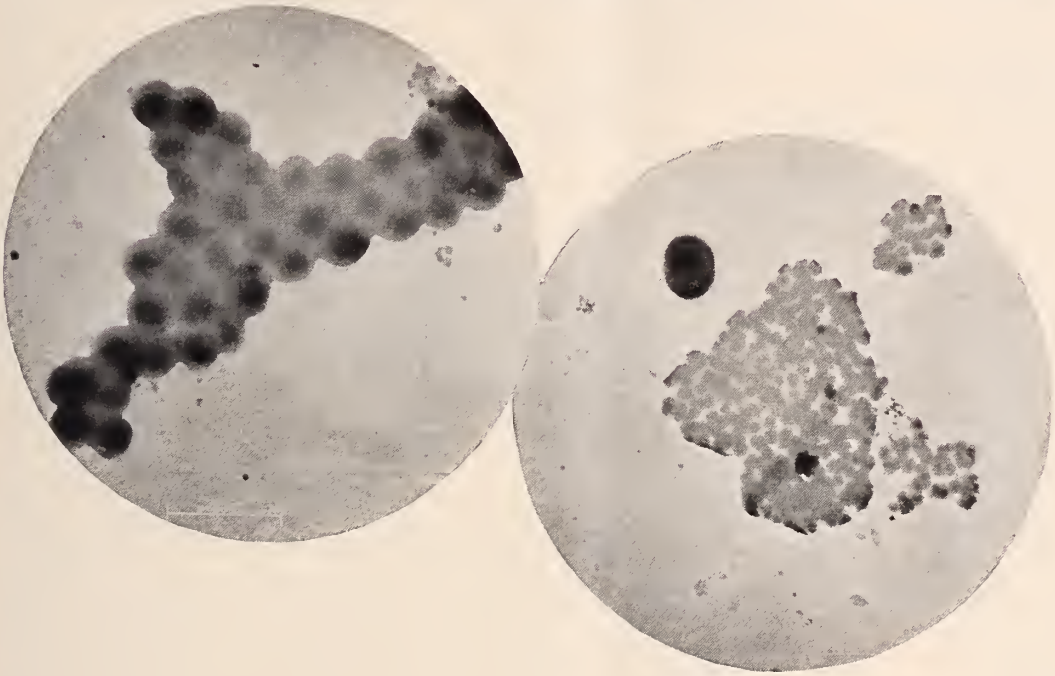
From an Article on "Abducens Palsy-Transplantation of Vertical Recti in Three Cases," by Roderic O'Connor, M.D., Oakland.—The surgeon and internist should be interested in this subject because this condition usually complicates some injury or disease. Also the otologist because the symptom occurs occasionally in suppurative process in the apex of the petrous portion of the temporal bone (Gradenigo Syndrome). *They should also be informed that relief is possible in spite of statements to the contrary, in most of the text-books on ophthalmology.* Therefore these patients should not be dismissed as incurable or told to wear a patch over one eye permanently but should be referred to the ophthalmologist early in order that the progress may be watched and operation done as soon as it is certain that power is not returning. . .

From an Article on "The Treatment of Fresh and Un-United Fractures of the Femoral Neck," by Ellis Jones, M.D., Los Angeles.—Of all types of fractures an intra-capsular fracture of the neck of the femur is the most disabling. It is fracture with the highest disability

(Continued on Page 28)

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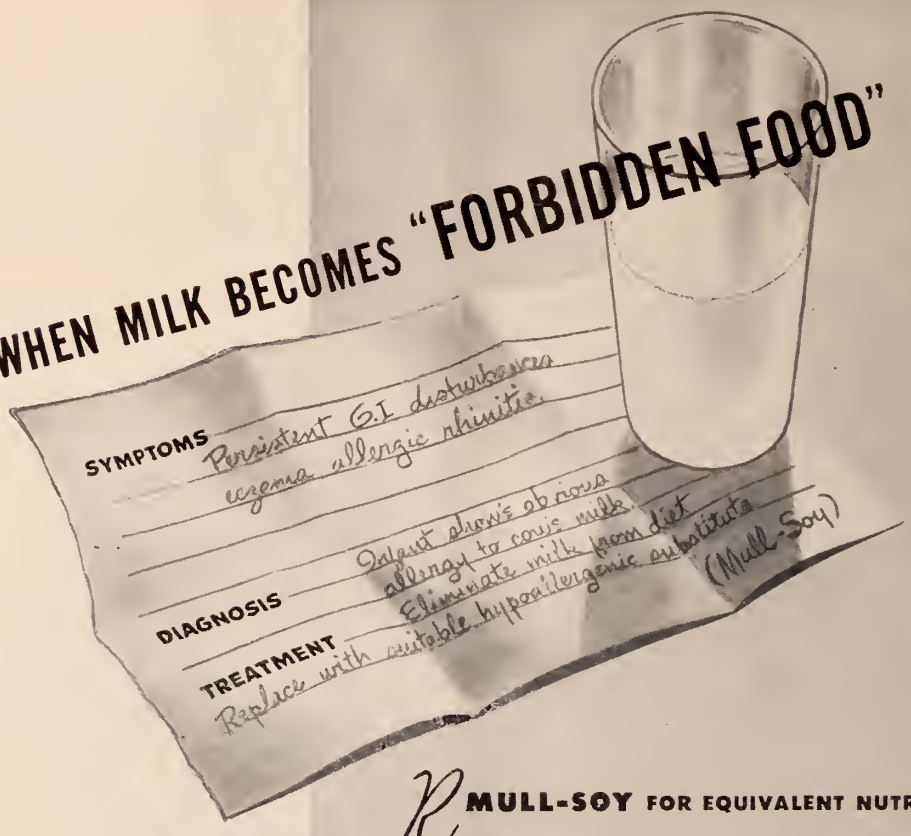


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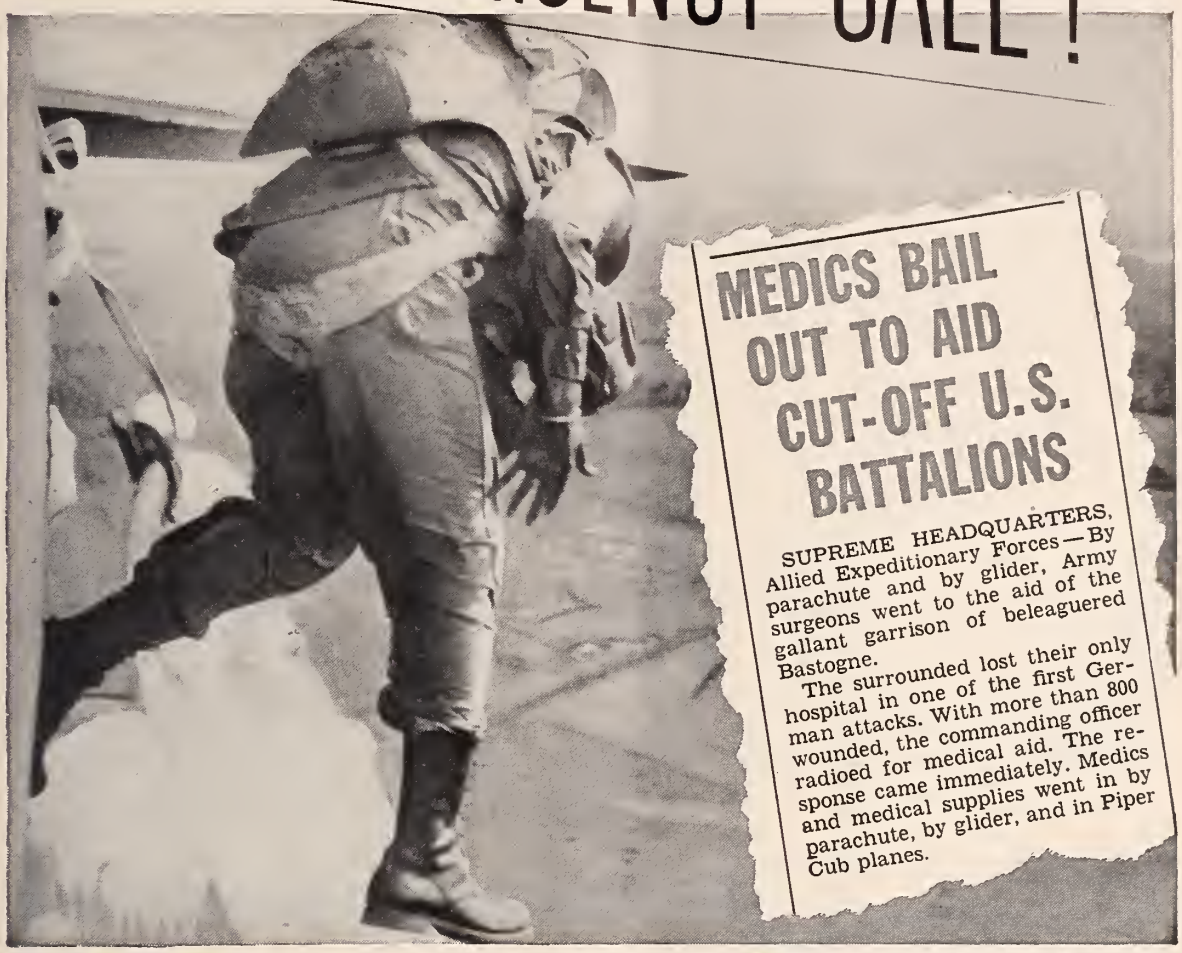
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131 STORES ON PACIFIC COAST

BOOK REVIEWS

(Continued from Page 22)

rating and the poorest functional end results. When treated by the usual conventional methods of extension, either by so-called Buck's Extension, suspension, or traction methods, the percentage of poor results is startling. . .

From an Article on "War Wounds of the Sinuses with X-Ray Plates," by Harold A. Fletcher, M.D., San Francisco.—The problem of instruments for sinus work was a very hard one in France until just before the armistice. The specialist had at his disposal very little other than the regulation ear, nose and throat canvas roll, the regulation box of eye instruments, and a few things that he could obtain from the general operating sets. Just before the armistice our requisitions for additional special instruments were being filled.

One serious drawback to the army roll is that its originators absolutely forgot, or did not recognize, the existence of the ethmoid, frontal or sphenoid sinuses. They did, however, provide a satisfactory trocar and canula for the maxillary sinus. . . .

From an Article on "The Examination and Classification of Aviators with Special Reference to the Effects of High Altitudes," by J. F. Grant, Captain M.C., U.S.A.

Physiology of Rebreathing and Aviation.

Physiological observations of men and animals living at high altitudes show that the following definite changes under reduced oxygen take place in the organism, namely:

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2. A fall in the lung alveolar carbon dioxide pressure and a corresponding rise in the alveolar oxygen pressure.

(Continued on Page 30)



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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

3. A rise in the arterial blood oxygen pressure.
4. An increase in the rate of blood flow. . . .

Excerpts from County Society Proceedings:

Fresno County.—The last and most interesting feature of the program was that prepared for Dr. Geo. H. Aiken. The stage had been nicely prepared and on the arrival of Dr. Aiken one of his old friends and co-workers arose and in eloquent language brought forth charges that were startling to the members who did not know the man about whom they were said. As Dr. Aiken, who has grown gray for these many years in the service of his fellow men, arose a bit staggered at the audacity of the proceedings, to defend himself, he was presented with a beautiful watch, which was the Society's way of expressing the honor and esteem in which the oldest, best loved and most honored member is held by his brother practitioners.

Dr. Aiken expressed his thanks to the Society, saying that this his 75th birthday would be the most memorable of his life. . . .

Los Angeles County: The Los Angeles County Medical Association Meeting, January 8, 1920, Friday Morning Club.—Dr. Rae Smith, the president, opened the meetings at the usual time.

Dr. Oscar Reiss presented the subject of "Infant Welfare Work in Los Angeles," describing in detail the organization of the welfare department, and presented a detailed study of 602 infants, particularly as to their feeding history. . . .

San Diego County.—The County Medical Society Bulletin appears this year in a new and much improved garb; it also makes its appearance twice a month, and is apparently paying it way from the array of legitimate advertisng that appears in its pages.

A very interesting session of the Society was recently held conjointly with the Bar Association. After an enjoyable repast at the Hotel San Diego the evening was punctuated with eulogies, serious and comic, of the two professions, while shafts of mirth and criticism, some barbed, some velvet encased, sped swiftly back and forth. From this scene of battle emerged groups of professional men with both their sense of humor and tolerance of their fellow man thoroughly stimulated, while

(Continued in Back Advertising Section, Page 34)



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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 62 MARCH, 1945 NO. 3

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

Francis E. Toomey	San Diego	1945
George W. Walker (Chairman)	Fresno	1946
F. Burton Jones	Vallejo	1947
Secretary-Editor	ex officio	

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER JOHN HUNTON
Advertising Representative for Northern California
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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

III. PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Continued)

Analysis of Proposed Sickness Insurance Laws.—The Voluntary Sickness Insurance Act proposed by the California Medical Association was printed in full text in CALIFORNIA AND WESTERN MEDICINE, for February, on page 65, and an analysis of its major features appeared on page 91.

Analyses of the two compulsory measures: the C.I.O. bill (A.B. 449) and Governor Warren's proposed law (A.B. 800) were given on pages 89 and 90.

Also, some sixty items dealing with the prospective legislation appeared on pages 68-92. Those informative comments were given space so that physicians who were too busy to have the time to follow the discussions of the controversial issues as given in the newspapers could orient themselves concerning the arguments put forth by the proponents and opponents of the various bills. Similar information on later legislative and allied developments is given in this current number.

* * *

Hearings During the Recess of the Legislature.—The 56th California Legislature recessed on January 27, to reconvene on Monday, March 5th. During the recess period the legislators returned to their homes, for presumable consultation with their constituents regarding bills that were submitted in the month of January, 1945. (A total of more than 3,385 proposed statutes were placed in the legislative hopper during January.)

The health insurance bills were referred by Speaker Lyon to the Assembly Committee on Public Health, of which Fred Kraft of San Diego is chairman, and that committee was given the task of holding hearings during the constitutional recess. Such hearings took place in San Diego, Los Angeles, Fresno, and San Francisco, time being alloted to persons who favored and those who opposed either the general plan of sickness insurance, or wished to be on record for or against special bills: A.B. 449 (C.I.O.); A.B. 800 (Governor Warren); A.B. 1200 (C.M.A.).

The newspapers played up the reports of these meetings to such extent that the reading public has had good opportunity to become aware that

compulsory sickness insurance legislation is still a highly complicated and unsettled, and therefore, a very controversial subject. It is to be hoped that the voters will sense that a final and simple solution of the problem is not available at the present time and that they will so inform their legislative representatives in Sacramento, suggesting careful study before any compulsory laws are enacted. For reference to what took place at some of the hearings above referred to, see pages 125 and 128.

* * *

Governor Warren's Error in Procedure.—It is to be regretted that Governor Warren and his advisers did not get together to draft his measure at least six months or so ago, instead of announcing his intention to draft such a law a brief two weeks or so before the 56th California Legislature convened on January 8. Press dispatches from Sacramento dated December 29, stated: "Governor Earl Warren today announced he will submit to the California Legislature meeting next month a plan of compulsory health insurance financed by a payroll tax on both employers and employees." The Governor's message to the Legislature on "Prepaid Medical Service" was presented on January 8. His conference with members of the Council of the California Medical Association took place on December 13. (See January CALIFORNIA AND WESTERN MEDICINE, pages 27, 29 and 34.) Had he prepared his draft in ample time, submitting his prospective law to the constituted authorities of the California Medical Association, the reasons why the organized medical profession of California objected to laws that would lower the quality of medical care, thus to become a distinct menace to the health interests of the people, would have been given him.

Similar criticism may be made concerning the manner in which the C.I.O. bill (A.B. 449) was brought to the front.

* * *

Up to the Present the Burden of Medical Care of the Poor Has Been Largely Borne by the Medical Profession.—Physicians through all the years have gladly given medical care to indigent and many other citizens, and that without financial compensation. Witness, for example, the services having money value of many millions of dollars, rendered each year by the staffs of physicians and surgeons of the public county hospitals of California. It follows, concerning the principle of providing adequate medical care to all citizens, Doctors of Medicine are in full accord with that objective. The record of the medical profession is clear on that point.

Some of the shouters who are demanding enactment of compulsory sickness legislation, but who, themselves, have had no such record of generous and altruistic service to their fellow men, would do well to remind themselves of this fact when they are exploiting some of their visionary and incompletely thought-out plans. As one listens or reads the mouthings of certain of the newer social welfare propagandists, one is reminded of what Carlyle said, when at a different period he spoke of such efforts as "this universal syllabub of philanthropic twaddle," or what some modern-day commentators perhaps would call "philanthropoid will-o'-the-wisps."

Wherefore, it can be stated again that in honest and faithful devotion and application of the best principles of humanitarism, the medical profession can be said to occupy first place.

However, while members of the medical profession may be willing to give medical care (1) to the indigent, (2) to the medically-indigent (persons with means sufficient for the three basic needs of food, clothing and housing), and even (3) to the group of wage earners immediately above the medically-indigent (those whose budgets, after they have availed themselves of accessories of American living, such as radios, electric washers and other equipment, and so on, often on time payments at the instance of high pressure salesmanship), it is not surprising that physicians hold that they should not be called on to accept compulsory sickness insurance plans that would lower the quality of medical care, not only for the above groups, but also for other citizens.

For, in the last analysis, the health needs of the above groups are associated with real or relative poverty, and the State might better concern itself with ways and means to eliminate that poverty, rather than to try to find its solution through the establishment of radical systems of compulsory sickness insurance that would only add to the misfortunes of those citizens.

* * *

Why are Sickness Insurance Plans Controversial?—The differences of opinion concerning sickness insurance laws rest therefore, not on the laudable objective to improve the distribution and quality of medical care, but rather upon the procedures and manner whereby the proposed betterment in medical service will be brought about.

It is true that in countries such as Germany (through Bismarck in the year 1811) and in England (through Lloyd George in 1911),—after gross neglect by those governments of the health of their workers prior to those years had made it necessary for those nations to institute sickness insurance by the capitation method—the health status of their respective populations in the lower wage groups was improved somewhat. However, those experiences in environments totally different than those of America preclude their use as shining examples to be imitated by the United States.

Before the institution of the Krankenkassen of Germany and the panel system of Great Britain, the medical care given to the citizens of those countries was on a much lower scale than that given to American citizens of similar economic groups during the same periods. This fact must not be forgotten in discussions.

And through all the years following the establishment of the German and English systems, the health care of American citizens in the lower wage groups has been of a better type than that prevailing in Germany and Britain.

The lower morbidity and mortality statistics, year by year, on record for the United States bear evidence on this point.

* * *

"State or Political Medicine."—The compulsory sickness insurance plans of Germany and Britain have produced what has been aptly called, "political medicine," a type of practice that is decidedly different from scientific medicine; as the latter is understood and practiced in our own Country under a system of free enterprise, with decent rewards for initiative and efficient service.

The proponents of the C.I.O. bill (A.B. 449) have stated that a physician operating under their capitation plan, granted he is able to obtain his full quota of such patients, would be able annually to earn about $12,000 *gross*. This would mean a yearly *net* maximum ceiling income of about $6,000. True, they add, the physician would have the right to secure additional patients, but with such a system in operation, this is more a theoretical than a real possibility.

* * *

The Costs of a Modern-Day Medical Education.—A physician prepares himself for his profession through some ten to fifteen years of hard study, (high school, 4 years; college of liberal arts, 4 years; school of medicine, 4 years; internship, 1 or 2 years), securing this training during some of the best years of his life. In addition to what he might have earned in business during that period, had he decided on a commercial career, his money outlay for education may amount to some ten to fifteen thousand dollars, or more.

Under the capitation plan, what could this medical man look forward to in the years to follow, even if he catered to the number of capitation patients that would be permitted him?

From the State, for such professional services, the physician would receive a net ceiling income not in excess of $6,000 per year, and with that amount he would be expected to maintain his station in life, purchase a home, clothe, feed. house and raise a family! Without being mercenary, the question may be put,—From what other profession or business are similar demands made?

* * *

Effects of State Systems of Medicine on Future Disciples of the Healing Art.—After five to ten years of operation under a system of compulsory medicine, with its regimentation and political supervisors and bureaucracies, the question may be asked,—Would the profession of medicine be as attractive in the future to high-thinking, altruistic, and well educated men and women, as it is today? It is not reasonable to think that under such conditions, our intelligent young people would aspire to become physicians in same number as at present. The educational standards of neophytes in medicine would be certain to deteriorate, and consequently, medical care of the future would be of a lower quality than at present.

* * *

Public Must be Made to Understand that "Political Medicine" is Poor "Scientific Medicine."—In the discussions concerning the compulsory C.I.O. and Warren sickness insurance bills now pending in California, it is unfortunate that so many citizens are under the impression that the proposed medical care under either of those plans would be as good as under the prevailing methods of private practice. If citizens could realize what will happen under the C.I.O. or Warren plans, they would be less willing to support either of those measures.

* * *

First C.M.A. Conference was Held on January 25.—The constituted authorities of the California Medical Association — the Council, Executive Committee, and Committee on Public Policy and Legislation—have taken steps to promote the objectives outlined in the resolutions adopted by the C.M.A. House of Delegates at its special session in Los Angeles, as printed in California and Western Medicine, for January (page 32).

The first C.M.A. conference with representatives of the State Government, Management, Labor, Agriculture and Affiliated Professions was held in Sacramento on January 25 (for report thereon, see California and Western Medicine, for February, page 85). Other conferences will follow while the Legislature is in session.

* * *

Probable Date of Adjournment of the Legislature.—It has been stated in the press that the present session of the California Legislature will probably continue through the month of May. It is possible that Administration measures bearing on general taxation and related matters will have first attention during the month of March. Thereafter, the battle concerning the health insurance bills will again receive special notice in the newspapers.

During these intervening weeks, the education of the public, insofar as physicians themselves can take part in such work, must be vigorously carried on. There must be no let-down in the campaign. Every physician has a responsibility, and must do his part in the promotion of efforts that will maintain a high quality of medical care, to the end that the best health interests of California citizens may be protected.

* * *

C.M.A. Members Will be Kept Informed.—Members of the California Medical Association,

through bulletins and other announcements, will be kept in touch with the activities of their state and county society officers. It is hoped, when a call for special action is received by a C.M.A. member, that the response in efficient coöperation and service will be promptly forthcoming.

Some excerpts from the resolutions adopted at the special session of the C.M.A. House of Delegates in January last, may be restated for readers:

"*Resolved*, That recent proposals to establish some form of compulsory health insurance in this State have come at the last minute without any opportunity for adequate consideration and planning by any of the many interested groups, or sufficient time for interchange of opinions and knowledge. . . .

"*Resolved*, That the California Medical Association is of the firm conviction that no fundamental and revolutionary change in the practice of medicine should be made under present wartime conditions. If disruption occurs in the rendering of medical service, the result can well be a catastrophe for the people of the State. . . .

"*Resolved*, That the California Medical Association cannot endorse any system of compulsory health insurance which has thus far come to its attention. . . ."

* * *

A Defective Sickness Insurance Law Would Be a Real Calamity.—To be kept in mind is the important fact that a defective sickness insurance law will aggravate whatever deficiencies in medical service may now exist. To inflict such a defective law upon the people of California would be unpardonable.

A careful study of existing needs by a properly implemented State Commission would seem to be in order, before California embarks upon a compulsory sickness insurance plan such as would come into operation if either the C.I.O. (A.B. 449) bill or Governor Warren's measure (A.B. 800), were enacted by the Legislature.

* * *

C.M.A. Bill (A.B. 1200) Offers a Solution.—If the proponents of immediate action in sickness insurance are in earnest about giving better medical care to certain wage groups, a proper beginning may be made through the enactment into law of the bill submitted by the California Medical Association (A.B. 1200).

The old slogan, "Stop, Look and Listen" should be taken to heart by those who advocate the enactment of compulsory sickness insurance laws that contain implications dangerous to the best interests of the public health.

Otherwise, if they should by chance succeed in their endeavors, they and the other citizens of California may long live to rue their undue haste with which they brought about the enactment into law of their immature, poorly conceived and impractical plans.

C.M.A. MEETING OF MAY 6-7, 1945

Session to be Held in Los Angeles—Will be a Local Meeting.—The Office of Defense Transportation does not give approval to meetings necessitating public carrier travel by more than 50 persons.

When the C.M.A. House of Delegates meets in Los Angeles on Sunday-Monday, May 6-7, 1945, the number of official delegates using public carriers from northern and other county medical societies will be held down to less than 50, as stated in California and Western Medicine for February, on page 97.

The meetings of scientific sections will be practically local in character; that is, attendance and participation will be largely by members of the Los Angeles and contiguous county medical societies, who can use their own automobile transportation in travel, returning to their homes on each of the two evenings, in that manner doing away with the use of hotel accommodations. Papers will be read "by title" (the essayist not being required to be in attendance), or through agreement, by some member of the Los Angeles or other nearby county society as noted in the California and Western Medicine item referred to above.

For the information of C.M.A. members who may look with suspicion upon a meeting under auspices as here outlined, as being too small in scope, it may be in order to call attention to the fact that only ten state medical societies have a larger membership than the Los Angeles County Medical Association. The number of members credited to the ten state associations of larger size, as listed in the *J.A.M.A.* of April 29, 1944, include: New York, 18,908; Pennsylvania, 9,951; Illinois, 8,623; (California, 7,550); Ohio, 6,752; Massachusetts, 5,528; Texas, 4,607; Michigan, 4,567; New Jersey, 4,294; Indiana, 3,397; and Missouri, 3,252.

The above figures are given to remind Los Angeles County and other members that, even though this year's session of the C.M.A. will be "local," it should be possible to have adequate attendance at the meetings of scientific sections, without conflicting with the rules of the Office of Defense Transportation.

In this, as at last year's session, there will be no scientific or commercial exhibits. Nor will there be any dinners or social events.

Meetings will be held, not in hotels, but in the Elks Temple lodge rooms and the headquarters of the Los Angeles County Medical Association.

The publicity regarding the scientific programs will be largely carried on through the Los Angeles County Medical Association.

All papers, whether read by title or otherwise, will be eligible for consideration and possible publication in California and Western Medicine, thus insuring up-to-date articles for readers of the Official Journal.

Members in and about Los Angeles who can attend under the conditions noted above, should make note of the days and arrange to be present.

In due course, additional notices pertaining to the meeting will appear.*

* See also item on page 137.

EDITORIAL COMMENT†

MILK-BORNE CARCINOGEN

For a number of years the staff members of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, have made genetic studies of spontaneous tumors in several intensively inbred strains of mice. Under natural methods of propagation, these strains showed widely different hereditary tendencies to the development of spontaneous breast tumors. At one end of the scale there were certain families, 95 per cent of whose members eventually died of mammary carcinoma. At the other extreme there were families in which the incidence of spontaneous breast tumor was as low as 0.5 per cent.

About 10 years ago[1] the natural method of propagation was purposefully or inadvertently altered, many of the young being reared by foster mothers. It was then noted that the fostered young tended to acquire the carcinogenic percentage of the foster parents. Thus, a 94.7 per cent susceptible strain was changed to a 0.7 per cent strain as a result of refractory (0.5 per cent) foster-feeding. A 0.5 per cent (refractory) strain became highly susceptible (89.8 per cent) as a result of 95 per cent susceptible foster-feeding.

Seven years study of foster feeding[2] has shown that foster modification of hereditary percentage is not due to a protective antibody in non-carcinogenic milk. It is apparently due to a deleterious "influence" in carcinogenic milk. This pathogenic "influence" is present in the milk of carcinoma susceptible mice during the entire lactation period, and is afterward demonstrable in aqueous extracts of the tissues of the fostered young. Adequate confirmation of these findings has been reported by other investigators.[3] Law[4] and Cloudman,[5] for example, found that the milk-borne carcinogenic "influence" also increases susceptibility to experimental inoculation with mouse leukemic cells.

Attempts to determine the nature of this milk-borne "influence" have been made mainly by a study of the same "influence" in extracts of lyophilized breast cancer. In his initial experiments Bittner[6] fed 10 young mice of a cancer resistant stock with 2 cc. of this carcinoma extract. Six of these mice developed spontaneous breast cancer by the end of 12 to 14 months. None of the brother or sister controls not given cancer filtrate developed breast tumor. It has been shown that the active principle in such carcinoma extracts can be partially sedimented in the ultracentrifuge (20,000 to 110,000 times gravity).[7]

Attempts to determine the chemical properties of this pathogenic agent are currently reported by Barnum[8] and his associates of the Division of Physiological Chemistry, University of Minnesota. Some of the reported chemical properties of this agent are of suggestive clinical interest. This is particularly true of their studies of its thermostability. In a typical experiment breast tumor tissues were homogenized with distilled water, and the resulting supernatant fluid divided into 5 aliquot parts. These were kept at 4°C., 24°C., 37°C., 60°C. and 90°C. for one hour. All portions were then brought to room temperature and an amount equivalent to 1 gram of original tissue was injected into young mice.

Of the 18 mice injected with the fraction stored at refrigerator temperature (4°C.) 9 mice (50 per cent) died of spontaneous mammary carcinoma on or before the 16th month. None of the non-injected controls developed tumors. About half of the carcinogenic titer was lost in the fraction stored for one hour at incubator temperature (37°C.). The extract was completely inactivated at temperatures of 60°C. or higher. The thermolability of the carcinogenic agent is therefore approximately the same as that of serum complement. This is of possible hygienic interest since it suggests that the milk-borne carcinogenic agent would be completely inactivated by ordinary methods of Pasteurization.

At least three plausible theories have been suggested (or are implied) in the reports of various investigators. First, the observed facts could be fully accounted for on the assumption that we are here dealing with a milk-borne carcinogenic virus. Thus far, the virus theory has not been adequately tested. The observed facts could also be accounted for on the assumption that we are here dealing with a milk-borne hereditary gene or its equivalent. This futuristic theory also has not yet been supported by adequate experimental evidence. Finally, the observed facts could be accounted for on the assumption that the milk factor is an organ-specific cytotoxin causing sufficient permanent injury to homologous tissue cells of the fostered young as to completely destroy its hereditary cancer resistance in late adult life. This theory finds some support in Law's[9] recent discovery that in certain inbred mouse strains, repeated injection of certain bile derivatives during infancy leads to a significant increase in the incidence of spontaneous carcinoma in later life.

These and other more complex plausibilities are now under investigation.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

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(References. Concluded on Page 115)

ORIGINAL ARTICLES

Scientific and General

COMPULSORY HEALTH INSURANCE*

RADIO BROADCAST ON LAWS SUBMITTED TO CALIFORNIA LEGISLATURE

STANLEY K. COCHEMS
Los Angeles

FELLOW Citizens of California: Governor Warren in addressing you Wednesday evening made a passionate plea for the immediate institution of prepaid health insurance in this State, in support of Assembly Bill No. 800, now before the Legislature. However, the Governor did not call his plan a compulsory plan until near the end of his address.

I will deal only with facts—facts important to you and to me, as citizens and taxpayers.

We will consider the two compulsory health insurance bills—the C.I.O. Assembly Bill No. 449, and Governor Warren's Assembly Bill No. 800. In essence these bills are very similar. The Governor and the C.I.O., through statements publicly made, are attempting to sell futures in a service which they do not own or control; and a service which now and for years to come cannot be delivered.

* * *

A false impression is current that compulsory health insurance means *free* medical care. That is not true. Any compulsory insurance costing taxpayers of California a minimum of $260,000,000 a year is not free. Proposed legislation, as widespread in its effect upon all people of this State and carrying with it a tremendous menace to this State's industrial and business position in competition with other states, must have the careful consideration of *every* citizen.

Men trained in tax matters—who are experts in the problems of business and industry—have studied the Governor Warren-C.I.O. Bills dispassionately and have termed these proposals *"outrageously impractical,"* and have amplified that statement by saying, that should either of these bills become law, California could not compete industrially with other states because of the tremendous handicap of added taxation.

* * *

Governor Warren, in an attempt to refute the statement that his proposal was hastily drawn, said that the question of compulsory health insurance had been considered in California for the past thirty years. That is true. But most of the studying and theorizing was done prior to 1918, and in 1918 the people of California voted 3 to 1 against a compulsory health insurance plan similar to the plans now proposed.

And little was done since 1918 except theorizing, until the California Medical Association decided to do something practical about it—decided to put into practice a voluntary prepaid medical service plan, following the age-old concept that the proof of the pudding is in the eating.

The California Medical Association plan, known as California Physicians' Service, has gathered the greatest amount of *factual* data relating to prepaid health insurance that has ever been gathered in *practice* in this country.

Thirty years of theorizing on the part of those who would create a Utopia by law, produced nothing but more theories. And now the C.I.O. and Governor Warren believe these theories should be tried—at enormous cost to us. They have been tried for sixty years in Germany with a result that you and I as citizens and taxpayers certainly do not want.

* * *

And now, to specific facts to prove how impractical these proposals are:

C.I.O. leaders have stated that it would cost $250,000,000 a year, plus administrative overhead, to be borne by the State out of general funds, to give to the 6,500,000 citizens, who are now beneficiaries under the unemployment insurance fund, an adequate type of medical care and hospitalization. In that estimate the C.I.O. leaders are quite correct. It would cost that much *at least* according to experience *gained in practice* by the California Physicians' Service, which has shown that a minimum of $40 per person per year is the cost—a total cost of $260,000,000 a year for 6,500,000 people.

The Governor Warren-C.I.O. Bills would raise money for this purpose by a 1½ per cent payroll tax to be paid by the employee and 1½ per cent by the employer, a total of 3 per cent. In the peak year of employment, 1944, that tax would have raised only $160,000,000. Immediately there appears inevitable a deficit *each year* of $100,000,000 which the State would be pledged to pay out of its general fund.

Senator Pepper, in his sub-committee's report to the United States Senate, showed that the cost of completely adequate medical and hospital service for a family of three for a year would be $241.00 or $80.00 per person. Senator Pepper is an ardent advocate of some plan to better spread medical care. Certainly Senator Pepper would not exaggerate the cost.

If we use Senator Pepper's estimate, the cost of providing such complete care to 6,500,000 Californians would be $520,000,000 a year. On that basis with only $160,000,000 raised by compulsory health insurance taxes, as proposed by the C.I.O. and the Governor's Bills, there would be a deficit of $360,000,000 *a year* which the State would have to meet with additional taxes.

Governor Warren is evading the issue in not discussing the very important financial aspects of these bills. If the State has to meet a minimum deficit of $100,000,000—and this might become a

* Radio script submitted by Stanley K. Cochems, Executive Secretary of the Los Angeles County Medical Association, for presentation over Statewide Blue network on Friday evening, February 23, 1945, at 9:45 P.M.

deficit of $360,000,000—if we accept Senator Pepper's figures—then our legislators, in all fairness to you and to me, must tell us before they pass such legislation, how they intend to raise such vast sums in addition to the money raised by the 3 per cent payroll tax.

There are three ways this deficit could be met, and you and I should have some voice in the method of raising it. The three methods are by doubling or possibly trebling the present sales tax; or by a heavy property tax on every home, farm and business; or by creation of drastic new and heavy taxes on every form of business enterprise in California.

So much for facts relative to the financial aspects.

* * *

Now for facts to prove how impractical these proposals are:

The medical services the Governor and the C.I.O. promise to deliver to the people for a price of hundreds of millions of dollars a year are *not available* now and will *not be available* for many years to come.

Before the war, California had 9,000 Doctors of Medicine in active practice—one doctor for 800 people, the national average. The war has taken one-third of these Doctors of Medicine. The population of this State has advanced from 7,000,000 to nearly 9,000,000. Today there is one doctor to each 1,500 people.

The shortage of medical men in the United States will remain serious for many years. Young men who had planned medical careers had their plans disrupted when called to military duty. Many of these young men will not consider preparing for the practice of medicine, if they are faced with the prospect of regimentation when they are graduated.

Every Doctor of Medicine in California is exceedingly busy today. If some of our people are unable to obtain adequate medical care, the chief reason is—there are not enough doctors. And remember, this situation will not be relieved when the war ends. For each doctor who returns there will be hundreds of men returning, swelling the population of California.

The promises of adequate medical service being made by the Governor and the C.I.O., under a system of compulsion, means that our doctors would be called upon to render from three to four times the amount of service they are now delivering. Today they are delivering to the utmost of their ability. The service that is promised is a physical impossibility and could only be approached if the doctors sharply reduced the service rendered to each patient,—and that means the service rendered to you and to me,—which has been the experience of compulsory health insurance plans in Europe.

Under normal conditions of private medical practice among people who are able to pay a physician for his services, the incidence of such demand for a doctor's services amounts to approximately 650 cases per year per 1,000 adults. From the practical experience gained by voluntary health insurance in California under the offering of full medical coverage, the demand immediately jumped to 1,300 cases per year per 1,000 people. In other words, the demand doubles when full insurance coverage is given, primarily because it is a human trait to attempt to get value received for the money expended, whether the thing received is essential or not.

And when children are added to the adult group under full insurance coverage, the figure jumps to 1,790 cases per year per 1,000 people. These are facts, not theories!

This constitutes a demand—not necessarily a need—for services which could not be met by the number of doctors now in the State or the number of doctors who can be trained within the next decade or two.

The Governor and the C.I.O. are promising—for hundreds of millions of dollars of your money—something that the Governor and the C.I.O. cannot deliver.

* * *

Much has been said of the demand for prepaid medical care. It is true that some practical method must be found and *will be found* to improve the distribution of medical care through practical experience being gained by voluntary plans now in existence and practical methods are being found. The problem cannot be answered by theory; it cannot be solved through "outrageously impractical" proposals.

The demand is not entirely or in any great degree for a *compulsory* program. A large percentage of the demand, as shown in a recent survey, is for some form of voluntary prepaid medical service.

Need and demand are different things. The Governor and the C.I.O. have made much of the so-called five million 4-Fs. For 30 years England has had compulsory health insurance. Experience in England has shown that 50 per cent—instead of our figure of 38 per cent—were rejected for physical and mental reasons. Physical standards demanded by the British were much lower than ours.

Senator Pepper's report to the United States Senate on January 5, 1945, presented factual data as to why men were rejected. There were 4,217,000 4-Fs. Reviewing the causes of rejection we can find no basis for believing that had a system of compulsory health insurance existed in this country before the war, this number could have been reduced appreciably.

* * *

The Governor and the C.I.O. make much of their appeal to increase the health standards of California. Our health standards today are higher than those of England and of Germany where compulsory health insurance has existed for years.

The health of the people of this State can be improved through a program of education,

through an improvement of living conditions, through teaching our people to understand the benefits, and then to make use of the many free medical services now rendered by our health departments in the control of contagious and avoidable disease.

The Governor declares that the voluntary approach has failed; that only 100,000 are insured by California Physicians' Service. The Governor failed to state, however, that other voluntary and group medical services are in existence in this State, and according to the report of the State Chamber of Commerce, 1,500,000 California citizens are now covered by this type of health insurance.

The voluntary approach is not a failure and subscribers to voluntary plans are growing rapidly in number.

Our thousands of young men in military service—our 3,000 California doctors in military service—should have a voice in the decision of these drastic proposals, which by no stretch of an active imagination can be considered emergency measures at this time. Study of prepaid health insurance in practice, not more theorizing, is needed before plunging California into a morass of debt.

Assembly Bill 1200, introduced by the California Medical Association, provides for no taxation, but would greatly encourage the growth of voluntary, prepaid medical service plans.

1925 Wilshire Boulevard.

DIAGNOSIS OF INDUSTRIAL POISONING*

Alice Hamilton, M. D.
Boston, Mass.

A RULE for the diagnosis of industrial disease was laid down way back in the seventeenth century, by Ramazzini, the first great student of occupational disease. He bade the physicians in Italy, when they had a case of illness in a working man, not to ask him only about his symptoms but to go carefully into all the details of his occupation; for without this knowledge, they would not be able to make a correct diagnosis. It cannot be denied that Ramazzini's advice is still needed, at least by medical students and hospital internes, for most medical schools still leave out industrial medicine from the curriculum and students graduate with more information about amoebic dysentery than about lead poisoning. And, as one who has had to go through many hospital records, I can assure you that the average interne has little intelligent interest in the history of the patient's work. Often he is content with the word "laborer," which tells us only that the man belongs to what our radicals call the "proletariat." Or, perhaps he goes so far as to write "lead worker," but that tells us far too little. We do not know how great the lead exposure was, nor how long it lasted, and those facts have an important bearing on the diagnosis. Mixing white lead paint in an open chaser may bring on a form of plumbism which would never occur in a man who handled freshly made lead grids for storage batteries. The slow accumulation of lead in the body gives rise to one clinical picture, the sudden flooding of the body with soluble lead, to quite a different one.

I remember a case which came before a compensation board with a claim for arteriosclerosis caused by lead and resulting in cerebral hemorrhage. The history showed that the young man had been employed for only six months in a lead foundry, handling metallic lead. Such a profound effect could not take place in so short a time and from so slight an exposure. On the other hand, an acute attack of maniacal excitement in a man who spent three days cleaning out the separator in a white lead works, should be accepted without question.

It is, however, not enough to know what the patient's job was: one must discover whether there was any poisonous substance in his immediate vicinity, for it is not safe to assume that because his job is safe, he is not exposed to poison. For instance, I was much puzzled by a case which seemed clearly one of lead poisoning, in a man working in a rubber plant where lead was added to the rubber in the mixing mills. He assured me that he worked only at a mill compounding leadless rubber, but a visit to the plant showed that in two of the nearby mills, lead was mixed with the crude rubber. Neither of those men was leaded, but the man working near by was. It was just one of those cases of oversusceptibility which we cannot explain.

On the other hand, it is not safe to assume that because a man is employed in a chemical works where poisons are produced or used, his sickness is occupational in character, for close inquiry may show that he is in the department making containers and never comes in contact with the chemicals. Often it is very difficult to discover just what the man's exposure has been. I remember a case of aniline poisoning during the first world war, when we in this country had to begin the production of aniline because the German supply was cut off. There was much chronic anilinism in those days, and in Akron the victims were called "blue boys," because they were deeply cyanosed and dyspnoeic, like men with cardiac decompensation. It was in the compounding and mixing rooms of the rubber plants that the aniline was used, and my man worked only in the heat vulcanizing department, yet he had a typical case. Finally a rubber chemist cleared it up by telling me that the heat of vulcanization resulted in the production of aniline-like bodies, which escaped when the vulcanizers were emptied.

Even when the manufacturer tells you frankly the composition of the solvent or thinner he is

* Guest Speaker's Address. Alice Hamilton, M. D., is Professor Emeritus of Industrial Medicine, Harvard University Medical School. Given before the Third General Meeting at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

using, or the welding rod or flux, the information may be misleading, for the purveyor of these may suddenly change the formula, as prices change, and not notify the users of the change. Thus cases of coal tar benzol come to light in establishments where only toluol or petroleum naphtha is supposedly being used. The new process of producing gasoline, by cracking, distillation at great heat, results in the formation of aromatic compounds, benzol, toluol, etc., so that the final product is not only gasoline, but gasoline-benzol, capable of producing the typical symptoms of benzol poisoning.

The second thing I wish to emphasize is the over-narrow rules we have adopted for the diagnosis of occupational poisoning. Under the influence of the compensation laws and the insurance companies, we have become too cautious. If we are dealing with an industrial case, we feel we must be absolutely sure that it conforms to the type of poisoning as given in the text books, those books with which we shall be confronted when we go before a compensation board. We feel we must be ready to defend our diagnosis with reference to the authorities and this leads us to accept a picture of an industrial intoxication which is correct, of course, but is not the only correct picture. In non-industrial diseases there are no such strict standards. Take those blood dyscrasias, Schultz' agranulocytic angina, and the various forms caused by the action of radio-active substances. Any variety of blood abnormality is accepted, no matter how it differs from that originally described. But not so, if the disease is of occupational origin.

When we were studying those distressing cases of radium poisoning in dial painters in New Jersey, the lawyers were insistent that we give them a definition of radium poisoning, so that they could go into court properly prepared for every contingency. We refused, of course, we knew that cases unrecognized at that time, would appear later on and we would have to keep widening the definition. And of course that happened, the slower cases developed osteo-sarcoma, but only after a long interval. As to benzol poisoning, I came across the discussion of a case which came before Richard Cabot's clinic, a man exposed to benzol, dying of either hemorrhage or septicemia, I do not remember which, but because the autopsy revealed a hyperplastic bone marrow, instead of the classical aplastic form, the diagnosis of benzol poisoning was rejected. I was called in on a compensation case in which benzol exposure was admitted, but the blood picture was not typical, there were regenerative and abnormal forms of red blood corpuscles, and so it was declared to be a case of pernicious anemia.

Now we have progressed beyond that rigid limitation, we can nowadays insist that benzol poisoning may result in any one of many blood changes, in accordance with the part of the bone marrow that sustains the severest attack. There may be anemia, or polycythemia; leucopenia or leucocytosis; complete aplasia or signs of regeneration. There may even be typical leukemia, of the myelogenous or the lymphatic type, no less than twelve cases are now on record and nobody can guess how many more might be had had not physicians been held back by too rigid ideas. The latest extensive study of benzol poisoning, made by groups in Boston and New York, resulted in the conclusion that in men a hyperplastic marrow is more usual than an aplastic, in women the latter is the rule. It is even suggested that our belief in the over-susceptibility of women to benzol may be founded on the rejection of cases of hyperplasia and acceptance only of those with aplasia, whereby most of the male cases have failed to be recorded. How many cases have been lost because a septic process dominated the picture, it is impossible to guess, but the diagnosis of Vincent's angina or septicemia has certainly covered many cases of benzol poisoning, for the disappearance of the protective substances from the blood has been repeatedly shown to be part of the action of this solvent.

The anoxemia of carbon monoxide may result in death of those cells which cannot stand the lack of oxygen. Most of the body cells, when destroyed can be regenerated but not the cells in the gray matter of the central nervous system and the basal ganglia. Moreover, although the cells in the walls of the smaller blood vessels may later be regenerated, for a time there is a weakened vessel wall and there may be a hemorrhage which, even from the smallest vessel, has serious consequences because it occurs in an important region, such as the gray matter of the brain. Such cases, that follow an acute gassing, are, I think, the most puzzling that come to us as industrial toxicologists. Several cases of atrophy of the optic nerve following a not too severe gassing have come to my attention. I felt I could not be positive on the first case I saw, but only a few years later I came across two such cases in the literature. As they were not industrial, they had attracted little attention, but they were just like the case I had rejected, the gassing had not been severe, but the effect upon the optic nerve had been very severe.

Another puzzling case was one of fatal hemorrhage in the course of typhoid fever. The man had been severely gassed a month before he came down with typhoid fever. He was progressing fairly well and had every prospect for recovery and then suddenly he had a fatal hemorrhage. The claim on behalf of the widow was that the gassing had weakened a vessel wall and caused the hemorrhage. This may have been true, I do not know, but no compensation board would accept an explanation like that as being anything but hypothetical.

A similar case of cerebral hemorrhage occurred in a worker in a steel mill in South Chicago, two or three months after a severe gassing. Something happened to raise his blood pressure sud-

denly and the man had a hemorrhage, but not fatal. His claim for compensation, of course, was also turned down. There may be all kinds of sequelae, depending on the site of the pathological changes which may be caused by the anoxemia of carbon monoxide poisoning, when the gassing has been prolonged and severe.

As for lead poisoning, there are still forms of it that puzzle us even after all the years of study of this occupational disease. For instance, there are cases in which the symptoms involving the joints, hardly ever the muscles, dominate the picture and obscure the diagnosis. That remarkable pioneer in this field, Tanquerel des Planches, who described a hundred years ago various forms of plumbism, warned the physician that he might see cases of what seemed to be rheumatism, with none of the ordinary symptoms of plumbism, yet of plumbic origin.

Carbon tetrachloride poisoning is not typically slow, gradual, chronic in its course. The typical history is one of a heavy exposure, resulting in an attack of nausea, headache and a little later a dark colored urine and some time after that evident jaundice, that is typical. The pharmacologists have done a great deal of work on carbon tetrachloride because of its use in the treatment of hookworm infestation. Their publications show that in animal experiments the lesions in the liver are the most conspicuous, but do not be misled by animal experiments. In human beings the symptoms that are referable to the kidneys are the most marked, in severe cases death usually comes from uremic poisoning. There are also cases of marked nervous disturbance, convulsive seizures, even neuropsychoses following an acute narcosis from carbon tetrachloride fumes. Even progressive muscular atrophy has been described. Two cases have come to autopsy which showed typical sclerosis of the liver.

It is important to remember that trade poisonings have not been confined to the trades. This danger penetrates into the home in many cases, from ignorant use of dangerous substances which are sold in an unlabeled can or a can labeled with utterly undescriptive labels. One of the Public Health Service men told me that he thought he had found 35 different names for carbon tetrachloride to be used in the home for dry cleaning, for painting, and still worse for paint removal, for treating floors and for removing shellac. All of these carry with them the danger of the same kind of poisoning that occurs in industry so it is not only the industrial physician that must bear the possibility in mind.

In closing I wish to emphasize the importance of reporting all cases of industrial poisoning. I know there is a tendency to report only those cases that are unusually interesting, but it is only by having all the manifestations revealed that we shall ever get a true picture of a poison. Why is it we say such and such a poison never causes such and such a condition? It is because so far it has not been reported and it may not have been recorded because the man who saw that unusual case is very busy and he has not written it up Some of you see many cases of occupational disease and it is really your duty to give those cases publicity, especially if there is anything unusual about them. If you think an industrial poison had anything to do with a certain case of illness, put it on record, because your contribution will help to make up the general picture which at present is certainly incomplete, even with regard to the most familiar of the poisons.

Now I believe we are to go over to the panel discussion:

Dr. Hamilton: My two questions will not take very long. The first is the effect of industrial poisoning on early pregnancies. An industrial poison may produce hemorrhage and cause abortion in that way. Benzol is the most striking instance of that. An industrial poison may enter the fetal blood through the mother's blood and result in death of the fetus. The most striking instance there is lead. There are very interesting statistics about lead from the older countries where women were long employed in dangerous lead trades whereas they have never been here. Lead is a poison to the germ cell and a leaded woman is likely to be sterile, if she conceives she is likely to miscarry, if the child is carried to term, it is likely to be born dead and, if it is born living, it is likely to succumb within the first year of life. A very interesting study in Japan showed that paternal lead poisoning, which has often been shown in animals, is also evident in human beings, for they were able to compare the marital histories of two groups of Japanese workers in a great storage battery plant, those working with the lead and those not coming in contact with the lead. They found a greater degree of sterility in the wives of the lead workers compared with the wives of those who were non-lead workers. Lead has been found in the blood of the fetus.

Carbon monoxide was used as an abortifacient in Roman times. Even when it did not seem to affect the mother severely, it did affect the fetus. Any poison which enters the circulation of the pregnant woman is very likely to have some effect on the fetus. I am giving you only the facts I know, but you can see there must be other poisons which would have an indirect effect on pregnancy. Certainly any condition that would cause convulsions might result in expulsion of the fetus.

. . . .

(2) What are the early signs of carbon tetrachloride poisoning? These are symptoms of a narcotic poison, increasing headache, dizziness and confusion, simply what occurs in the early stages of any form of narcotic poisoning. If it goes on day after day there may be a gradual loss of health which will not be at all characteristic. There is nothing that is characteristic of the early stages of carbon tetrachloride poisoning. The symptoms are just like those caused by any one of the narcotic group.

Hadlyme, Conn.

LIMITATIONS OF OBJECTIVES IN PSYCHOTHERAPY*

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THE future historian of medicine will describe the beginning and the middle of the 20th century as characterized, on one hand, by the greater recognition and understanding of the neuroses and, on the other hand, by the development of a rational psychotherapy of the neuroses. Progress in treatment usually takes place with adequate crystallization of the various disease entities, so that the special problems in each condition can be attacked. There is little doubt that the greatest understanding of the neuroses has come to us through the teachings of Freud and his students. To be sure, there were many contemporaries of Freud who had approached the problem of neuroses in the same manner, and who held many of the ideas which Freud expressed at the same time. In this country, certainly, Adolf Meyer developed quite independently an approach to the psychoses, which paralleled in many respects Freud's ideas about the neuroses. We all know that scientific discoveries are seldom arrived at by one person. There are usually several investigators who simultaneously come upon the same idea, as was the case with the discovery of the principles of heredity, the discovery of insulin in the treatment of diabetes, liver in the treatment of pernicious anemia, etc. Freud's genius consisted largely in the fact that he did not try to approach the problem of the neuroses from the point of view of structural anatomy, which in his time was the only scientific approach to the progress of medicine. Freud observed, quite correctly, that in the neuroses one does not have a disturbance of any one organ, but that the whole organism is disturbed, and the disturbance is characterized by the difficulties in articulation of the individual to his immediate social group. He was also keen enough to observe that the organism is never the same, that its reaction changes constantly, hence he felt that the human organism should not be studied from the point of view of structure, but as an ever-changing body, i.e., a body in motion. Freud then proceeded to apply the technique of physics rather than anatomy to the study of nervous disturbances in human beings. This is what really constitutes the so-called dynamic approach about which we at present speak so much. The earliest writings of Freud contain terms of the physics of his day, such as vector, polarities, valences, quantities of libido, etc.

Freud's therapeutic ambitions were modest. He felt that with proper understanding of the drives of the individual, and of the repressions and frustrations which curbed these drives, and by the employment of the special technique of unraveling conflicts, one could clear up a certain amount of amnesia which accounted for so much unmotivated and frightening behavior. By means of such therapy Freud felt the patient was bound to become better, especially if the therapist was aware of the fact that he was serving as a lightening rod upon whom the patient could discharge many of his childish, immature emotions. Freud was frequently skeptical about the therapeutic efficacy of analysis and was more proud of it as a research tool than as a system of psychotherapy. There was good reason for his modesty in the field of therapeutic ambitions. As a young man he had seen some spectacular and brilliant results by some of the best psychotherapists in the world, such as Charcot and Bernheim. He realized full well that he could not possibly match his results with theirs. Freud again demonstrated his genius by the fact that he was rather unimpressed by the spectacular therapy that he saw. He, being primarily an investigator, wanted to learn what caused the puzzling conditions that he saw constantly in the big Vienna clinics and in his own private practice. The followers of Freud, operating and experimenting with psychoanalysis, found that they had at their hands a very powerful tool, which not only cleared up symptoms but frequently affected profound changes in the personality of the patients. As a result of psychoanalysis one occasionally saw a complete change in patients; some of them seemed to be new, reborn people. Patients suddenly found themselves in possession of great stores of energy which they now could use freely and effectively, so that they became different persons. The psychotherapist who mastered psychoanalysis became ambitious to produce such changes rather than to relieve symptoms in patients who came for treatment. The whole practice of psychotherapy and psychoanalysis is changing. For the past few years, patients who have come to psychoanalysis have not come for treatment of symptoms, but for changes in character so that they might become more capable, more efficient, more fully developed, more mature human beings. As Helena Deutsch puts it, the character of neuroses to be treated has changed. It is no longer the severity or mildness of the symptoms which is important, but the so-called residual personality. Psychotherapists are speaking constantly of deep therapy, implying that it is the only therapy worth mentioning. In presentation of case material, one constantly hears apologies for "superficial" treatment of the case and the lack of a "deep approach." Competent psychotherapists apologize for the excellent results because they are not able to offer elaborate explanations of why the patient improves. There seems to be an impression that the improvement in the patient, unless it is obtained through psychoanalysis, is temporary, and that the patient is doomed unless he has the benefit of analysis. At the same time the situation in the country as a whole has changed a great deal in the past 25 years. We

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have never had in this country the tremendous hostility to analysis which was the fate of analysis in Europe. There, quite rightly, the psychoanalysts felt scorned, rejected, humiliated, and most of them isolated. Many became extremely sensitive, suspicious and mistrustful of medical men. Unfortunately, this attitude persisted after their arrival in this country. In America now, the general practitioner, the internist, the gynecologist, the pediatrician, are aware of the existence of neuroses in patients, they recognize them, and they are perfectly willing to refer patients to the psychiatrist for treatment. The referring physician cares very little what technique the psychiatrist is using as long as his patient gets better. There is no real rift between psychiatry and psychoanalysis. In connection with the war, there has been a tremendous education of doctors in the fundamentals of psychiatry through the medium of the Army and Navy. The large number of physicians in the Armed Forces are learning to recognize the neuroses in their patients, and are anxious for the help of a psychiatrist. Not being handicapped by fear of competition, doctors in the Army and Navy are able to practice the finest medicine possible.

Consultations are frequently sought and exchanged, and a psychiatric point of view is appreciated by the military. Upon discharge of a large number of men from the Armed Forces on account of neurotic disabilities, a large group of men will appear in the community who will be aware of the need for psychiatric care and who will undoubtedly seek it. With such a terrific pressure in this crisis the well-trained psychiatrist must justify his existence by helping as many people as he can, even though it is more lucrative and in some respects more interesting to restrict himself to the field of psychoanalysis. I must say, since the problem began to be appreciated even before the war, there have been attempts to treat several patients at a time by means of group therapy. Thus far, it has been most successful in the treatment of children and institutional cases. In the field of individual therapy, there has been a great increase of psychiatric clinics throughout the country, and the leading psychoanalysts have attempted to solve the problem by organizing special clinics where patients could be treated by psychiatrists who have psychoanalytic orientation or insight, that is, persons who are specially trained in the understanding of the dynamics of therapy.

In relation to the war, we are forced to examine our goals. Are we attempting to change people, or is it our job to cure symptoms and to secure a better adjustment of the patient to his family, his friends, and to his work? Should we become imbued with a lofty ideal to reconstruct and change people, assuming that we have the capacity to do so? We then have to deal with the questions of ultimate values; almost a philosophical or theological problem. If we look upon psychiatry as a part of medicine, then our aims and ambitions are much clearer. The aim of therapy in medicine is to make the patient more comfortable, to assist nature in healing the patient's illness, and, in cases of serious and chronic illnesses, to make the load as easy as possible, and help the patient to function as well as his limitations will permit. If we would be willing to accept the same modest ideals in the practice of psychotherapy, then our knowledge is quite sufficient to achieve such a goal. We must be aware of the limitations of our method, but, on the other hand, we can help more people, we can make our therapy more available for larger groups even though we forego the pleasure of effecting complete personality change in a few patients. The relinquishment of this latter goal is accompanied to some extent by the regret of giving up our own feeling of omnipotence.

It may be well to illustrate my point of view with the case reports.

REPORT OF CASES*

CASE 1.—A woman in her thirties, who had been married for a year, came to me because she had been very upset for the past month. Her husband was an army officer on the Atlantic Coast, and she wanted to join him as he was more or less permanently stationed in one of the big army camps there. The patient was overjoyed at the idea of being with him since they had been separated shortly after marriage by the war. She made preparations to complete her job as a bookkeeper in a large wholesale house, and planned to join her husband within the month. Suddenly she felt she was unable to do so. She entirely lost her energy, could not seem to complete her job, would cry at her work and could not bear the idea of leaving her mother and sister with whom she had lived in close association for the past 20 years. She had occupied the same house for many years, she had had the same job since her graduation from business college, and she had developed a very fixed routine of work from which she never departed. She was a skillful and efficient bookkeeper, and had not thought much about marriage until she was getting into her thirties, when she met the man who fell in love with her and with whom she fell in love. She was very happy in the engagement period and in the first few months of marriage until her husband left for the army camp. It never occurred to her that she would have difficulty in leaving home and joining her husband. It was a shock to her that she had doubts and misgivings about leaving the city.

When I saw her she was crying, told me that she had lost her appetite and ambition, could not work, and constantly ruminated about the fact that she was so disloyal, and that she could not make herself finish her work and join her husband. It was quite obvious that the patient was suffering from a depression in somewhat of an obsessive personality. In the first interview, she wanted to discuss symptoms more and more, as well as the various elements that entered into her conflict. She was getting rapidly worse as her sense of guilt was mounting. I decided it would be best for the patient if she had a small immunizing experience, which would prepare her for the major breaking off from the family. The patient was a large, husky girl and I asked her if she took part in athletics. She told me that she was an en-

* A third case report will be given in the author's reprints.

thusiastic hiker, but that she had not done much walking during the past several years. I sent her away to a small country hotel in the midst of beautiful hiking country, with instructions to hike a great deal, and I gave her sedatives for sleep. Within two weeks the patient improved a great deal, even though she had a stormy time for the first few days. She returned to the city, completed her job within a week, and was off to join her husband. I hear from her occasionally and she is apparently very happy.

COMMENT

In this case we have undoubtedly a very rigid obsessive individual, and what she really needed was more elasticity in her personality so that she could more easily meet the various stresses of life. The immediate problem, however, was for this girl to overcome her ambivalence, to get over her depression and to join her husband. With the release of her aggression in walking, the trial separation from her family was effective in removing her symptoms, at least for the time being. I see no reason why this patient should not remain a well-adjusted human being who is decent, affectionate, and loyal to her husband. It is quite obvious that any one of you here could duplicate in your practice many similar cases in which you would have been just as successful as I have been, and I do not see that either you or I have to be ashamed of our therapeutic results or doubt their permanence or value.

* * *

CASE 2.—Some problems of sex adjustment are extremely easy to treat without the necessity of embarking upon an elaborate procedure of a complete personality review. A young army officer who was referred to me by a genito-urinary surgeon came to me with the complaint that he had erections but no emissions. He stated that he was very happy in married life, his wife was a nurse with whom he had been in love for a year before he married her. Prior to marriage the patient had had relations with her which were very satisfactory. Immediately after the wedding, however, he noticed that no matter how long the intercourse lasted there was in the first place lack of any sensation, and secondly, no emission. He had complete lack of feeling, even though he loved his wife dearly. I told the patient in the first interview that I had no idea what his difficulty was due to, asked him to tell me something about his family. The patient began to talk about his parents, and stated that his mother had come with him from the middle west and had left his father because of trouble during the past few years. In the presence of the patient who was the only son, the mother complained of the fact that her husband was impotent. In so many words she told the boy, my patient, that that was the cause of her unhappiness. As the patient was telling the story he admitted that he had made a resolution there and then that he would do everything in his power to satisfy his wife and that he would not be impotent. He began to look upon intercourse as a responsibility and a duty, especially if it came in married life. As the patient went on telling the story he agreed with me that after his marriage, intercourse became a matter of duty, responsibility, a compulsion and that he resented the fact that he had to do something which was more or less forced upon him, as it had been on his father by his mother. At the end of the interview the patient began to laugh. He called me up the next week and said that everything was O.K. He came in a week later and described in great detail the pleasure his wife and he had had in the sex adjustment they had achieved. Since then his wife has become pregnant.

COMMENT

Unfortunately, there are many more cases where we have failures rather than successes, and it seems to me that the immediate task of psychotherapy is extensive research into the process of brief psychotherapy. We should collect, very carefully, series of cases where we have success and where we have failure, and especially those cases in which we have failed and someone else has succeeded. On the basis of such careful analysis of all data, we ought to be able to develop intelligent rational techniques for helping our patient both quickly and effectively. All this, however, does not unfortunately eliminate extensive training of the future psychotherapist.

No matter how intelligent, intuitive and kind he may be, the future psychotherapist must receive extensive training in both the obvious and the more subtle mechanisms of therapy. Unfortunately, the psychiatry departments of our universities do not offer any extensive course in psychotherapy. The only places where such training can be obtained are the various psychoanalytic institutes where intensive and well-organized courses in the dynamics of therapy are offered. It is high time that there be a closer liaison between the psychoanalytic institutes and the medical schools.

SUMMARY

In the past decade neuroses have been more readily recognized by the medical men, and, in response, more effective methods of psychotherapy have been developed. Psychoanalysis has been successful not only in removing symptoms, but in favorable cases affecting profound beneficial changes in the personality of the patient. Good psychotherapists have become somewhat scornful of their favorable results, because they have not been obtained by "deep" psychotherapy. The chairman suggests that the aims of psychotherapy should be clearly defined as in other branches of medicine. Extensive research is needed in utilizing present knowledge for development of quick, effective psychotherapy reaching large groups of patients who are needing it.

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ENDEMIC TYPHUS FEVER IN SOUTHERN CALIFORNIA*

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AND
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TYPHUS fever first came to serious attention in California in 1916 when Mexican laborers, imported to work on railroads, brought the louse-borne disease into the State.[1, 2] Most of the 31 cases occurred in labor camps, and the disease was controlled by delousing and sanitation procedures conducted by the State Board of Health with the coöperation of the United States Public Health Service. Since that time there have been no epidemics of typhus in California. Maxcy[3] records the first case of endemic typhus in California as occurring in San Francisco in 1915 and the second in the same city in 1919. He records the first case in Los Angeles in 1920, followed by four cases in 1921.

The present paper deals with endemic typhus during the period 1922-1942, based upon detailed data on individual cases furnished to the authors by the California State Department of Public Health. The data from 1922 through 1939 were furnished to the senior author in connection with a study of the extension of endemic typhus fever in the southern United States.[4] Since the data provided much more detail than could be presented in that report, it has seemed worthwhile to record it separately, and the California authorities have been kind enough to furnish similar data through 1942. Halverson[5] has reported briefly on the trend of the disease through 1941.

Very recently, Beck, Bodily and O'Donnell,[14] of the Virus Unit, Division of Laboratories, and the Bureau of Epidemiology, California State Department of Public Health, proved the existence of murine typhus in California by isolating a murine strain of Rickettsia from the brain of a rat trapped in a poultry plant located in a semi-rural district of San Bernardino County where a case of typhus had occurred in a woman employed as an egg packer. This is the first laboratory proof of the existence of murine typhus in California.

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GEOGRAPHICAL AND CHRONOLOGICAL DISTRIBUTION

Table 1 shows the distribution of reported cases by years and their allocation to the probable locality where the infection was acquired. The cases reported as typhus to the State Health Department totaled 216, but one of these in a four-year-old child at Needles, in San Bernardino County, has been omitted from the analysis because of doubt as to its true etiology.

Table 1 shows that of the 215 cases, 152 were allocated to Los Angeles County, 45 to San Diego County, two to Orange County, and one each to the counties of Santa Barbara, San Joaquin, San Francisco and Solano. Among patients allocated to San Diego County are five which apparently contracted the infection at one or another of the race tracks near or just across the Mexican border.

In addition to the counties specified above, seven cases have been allocated to the State of California in general because the source of infection could not be localized, and three cases have been allocated to Texas, one to Hawaii and two to Mexico.

At the foot of Table 1, it is shown that 17 of the 45 patients allocated to San Diego County apparently became infected in San Diego City, and that 125 of the 152 patients in Los Angeles County apparently became infected in Los Angeles City.

The above figures indicate that the problem of endemic typhus fever in California has been, up to the present, limited almost entirely to two southern counties, San Diego and Los Angeles. This is further emphasized by the facts that one of two patients in Orange County may have become infected in Los Angeles County, that the case in San Joaquin County had a negative Weil-Felix reaction, that the case in San Francisco County was a boatman who had visited ports in southern California, and that the case in Solano County was diagnosed only from clinical symptoms. All of these counties except Orange are in central California. Map 1 shows the southern part of California with the number of cases reported from each county in this area.

TABLE 1.—*Typhus Fever Cases Reported in California 1922-1942 by Location of Probable Origin*

	YEAR																					
	'22	'23	'24	'25	'26	'27	'28	'29	'30	'31	'32	'33	'34	'35	'36	'37	'38	'39	'40	'41	'42	Total
COUNTIES																						
San Diego	..	..	..	..	..	..	1	..	..	..	..	..	..	..	5	6	7	4	3	6	13	45
Orange	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	1	..	..	..	..	..	2
Los Angeles	8	15	16	..	3	..	..	..	1	2	1	2	3	2	3	7	14	24	15	19	17	152
Santa Barbara	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	1
San Joaquin	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	1
San Francisco	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
Solano	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	1
STATES																						
California	1	1	..	..	..	..	..	1	..	..	..	..	..	1	..	..	..	1	..	..	1	6
Texas	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	2	..	..	1	..	..	3
FOREIGN																						
Hawaii	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	1
Mexico	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	1	2
TOTAL	9	16	16	0	3	0	2	1	1	2	1	4	4	3	9	16	21	30	19	25	33	215
CITIES																						
San Diego	..	..	..	..	..	..	..	..	..	..	..	..	..	..	3	2	3	1	1	..	7	17
Los Angeles	8	14	15	..	2	..	..	..	1	1	..	2	2	2	6	6	12	20	9	13	11	125

The chronological distribution of reported cases is also of interest. Considering only the southern part of the State, only one case occurred in San Diego County prior to 1936. Beginning in that year, from three to seven cases occurred annually until 1942, when 13 cases were reported. In Los Angeles County cases increased from 8 to 16 in the years 1922 to 1924. With the exception of three cases in 1926, no more cases were reported until 1930. From then until 1936 from one to three cases were reported each year, after which the annual number has been larger, reaching a peak of 24 cases in 1939.

TABLE 2.—*Cases of Typhus Fever in California 1922-1924 and 1925-1942 by Month and Season*

	1922-1924 Years			1925-1942 Years			Total	
Month	No.		%	No.		%	No.	%
Jan.	1			9			10	4.7
Feb.	2	7	17.1	8	22	12.6	10	4.7
March	4			5			9	4.2
April	0			6			6	2.8
May	1	1	2.4	18	31	17.8	19	8.8
June	0			7			7	3.3
July	5			13			18	8.3
Aug.	3	10	24.4	14	46	26.4	17	7.9
Sept.	2			19			21	9.8
Oct.	11			32			43	20.0
Nov.	9	23	56.1	22	75	43.2	31	14.4
Dec.	3			21			24	11.2
Total	41			174			215	

The most interesting point in connection with the chronological distribution in Los Angeles County is the sudden cessation of occurrence in 1925, and the almost complete absence of cases until 1930 when a very gradual increase began. It will be recalled that in the winter of 1924-25 an epidemic of pneumonic plague occurred in the City of Los Angeles.[6] In the control of that epidemic 210,000 rats were trapped and extensive rat proofing procedures were instituted. It seems probable that this campaign not only eliminated the rat and rat-flea sources of plague, but also reduced the corresponding sources of typhus to a level which prevented, for over a decade, the occurrence of more than a few cases in man. The increase beginning in 1937 was practically coincident with that in San Diego County, and also parallels the progressive increase in Texas and the southeastern states.[4,7] The cessation of cases in 1925 also indicates the probability that most if not all of the cases in Los Angeles County from 1922 to 1924 were acquired from rat-fleas rather than from human lice.

In 203 of the cases the data indicated whether the infection was probably contracted in urban or rural areas; 185 indicated an urban source and 18 a rural source. This demonstrated that the problem in southern California, up to the present time, is predominantly an urban one, as in other parts of the country. The occurrence of some rural cases, however, indicates that a further spread to rural areas similar to that in Georgia and Alabama may occur.

SEASONAL DISTRIBUTION

Table 2 shows the distribution of cases by month and season. Separate figures are presented for the years 1922 to 1924, and for 1925 to 1942. It will be seen that October is the month of highest incidence in both periods, with November ranking second. In both periods the autumn months show the highest incidence and the summer months the second highest. In the period 1925 to 1942 the spring months ranked third and the winter months fourth. In the period 1922 to 1924 a smaller proportion occurred in the spring than in the winter months, but the number of cases is too small to make this difference significant. This seasonal distribution conforms in general to that of murine typhus in the southern United States, and is quite the opposite from louse-borne typhus in temperate zones, where the incidence is highest in winter and spring. It supports the probability that most of the cases from 1922 to 1924 were flea-borne rather than louse-borne.

TABLE 3.—*Cases of Typhus Fever in California 1922-1942 by Age Groups*

Age Groups	Cases	%
0-9	1	0.5
10-19	20	9.5
20-29	49	23.1
30-39	57	27.0
40-49	30	14.3
50-59	33	15.6
60-69	20	9.5
70-79	1	0.5
Total	211	100.0

DISTRIBUTION BY AGE, SEX AND OCCUPATION

Table 3 shows the distribution of cases by ten-year age groups. Four cases of unknown age are omitted from this table. It will be seen that the largest percentage of cases occurred in the 30-39 age group, with the age group 20-29 ranking second, 50-59 ranking third, and 40-49 ranking fourth. This proportionate distribution of cases in age groups does not of course indicate the relative incidence of the disease in the corresponding age groups of population. Such an analysis, based upon the age distribution of the population, would probably show the highest incidence in later age groups. An analysis by sex shows that 73 per cent occurred in males and 27 per cent in females. This corresponds to the relative sex incidence in murine typhus in other parts of the country.[8]

Table 4 shows the distribution of cases by general type of occupation. The largest single group comprises housewives. Their principal place of exposure would be expected to be in the home, and the same can be said of children and students, although in neither case can infection elsewhere be excluded. All of the other occupational classifications, which together comprise the great majority of the cases, indicate the probability of

infection in their occupational locations, although infection of some of these persons may have occurred in the home. Further examination of the data on the 58 female cases indicated that only a minority (25) were housewives, and eight were children and students, while 19 of the remainder were engaged in gainful occupations where they might have been exposed to rats.

TABLE 4.—*Cases of Typhus Fever in California 1922-1942 by Occupation*

Occupations	Cases
Housewives	25
Factories, Warehouses, Docks, Boats	24
Stores and Markets	21
Service Trades, Salesmen	21
Office, Professional, Teaching	17
Eating Establishments, Food Processing	14
Ranches, Farms, Horses	13
Children, Students	13
Railroad Workers, Laborers	10
Unemployed	9
Other	18
Unknown	30
Total	215

With reference to exposure to lice, the epidemiological data stated such possible exposure in 17 cases, but in 14 of these, possible exposure to rats was also indicated. It is interesting that the first mention of contact with rats is in connection with a case occurring in 1924, two years before the publication of Maxcy's paper[9] suggesting a rat reservoir of endemic typhus. The second mention of rats is in connection with the 1932 case, after which contact with rats was frequently mentioned. Conditions favoring exposure to rat-fleas are, however, described in connection with many of the earliest cases.



Chart 1.—Map of Southern California showing number of cases of typhus fever reported from each county, and from Los Angeles and San Diego cities, 1922-1942.

METHODS OF DIAGNOSIS AND CASE FATALITY

The Weil-Felix test was performed in 187 cases. In 40 of these the reaction was positive but the titer was not reported. In 135 the reaction was positive in a serum dilution of 1 to 160 or greater. In 9 it was positive in a dilution of less than 1 to 160, and in 3 it was negative. In 25 cases the data did not state whether or not the Weil-Felix test was performed. One case was proven by guinea pig inoculation and 1 case was stated to have been diagnosed on clinical symptoms alone.

There were 7 deaths in this series, or a case fatality rate of 3.2 per cent. The ages of the fatal cases were as follows: 27, 40, 47, 54, 57, 58 and 69. Except for the 27-year-old case, these conform to the usual age distribution of fatal cases of murine typhus in the United States.[8] The 27-year-old case occurred in a Filipino in Solano County, north of San Francisco. The diagnosis was based entirely on clinical observations.

ADDITIONAL POINTS IN EPIDEMIOLOGY

In 13 instances more than 1 case occurred in the same household in the same year. In 10 of these instances there were 2 cases and in 3 instances there were 3 cases in the same household. The time intervals between the onset of cases in the same house ranged from 3 days to nearly one year.

In 2 additional instances personal contact was reported between cases at close intervals, the patients not living in the same house. One of these instances involved 4 men who became ill within 3 weeks; 2 of them were partners in a shoe store. The other instance involved a female attendant in the San Diego County Hospital who became ill after being in contact with a case in the hospital for a period of seven weeks.

Cases on ranches or farms, or connected with race tracks on the Mexican border, were reported only since 1936. This suggests that the reservoir of infection has recently spread into rural areas, partly from the large cities and partly from northern Mexico.

The 3 cases allocated to Texas were in persons who apparently were exposed in traveling by motor car to California. The case allocated to Hawaii was in a white woman who crossed the Pacific from Shanghai, stopped in Honolulu, and was ill upon arrival in San Francisco. The first case allocated to Mexico was in a woman who became ill 3 days after returning by automobile from Mexico City. The second case was in a mining engineer who was ill on arrival from Mexico. Both of these may have been louse-borne cases.

One case occurred in a Russian Jew, age 32, who stated that he had had typhus in Russia 20 years previously. This is of interest in view of the opinion of Zinsser[10] that Brill's disease in the northeastern seaports of the United States represents an exacerbation of Old World typhus in individuals who acquired the louse-borne disease previous to emigration to this country.

COMMENT

The data reported in this paper indicate that the problem of typhus fever in California is still limited primarily to Los Angeles and San Diego Counties, particularly to the large cities, and that there is an increasing problem in those areas, the largest number of cases to date having been reported in 1942. The locally acquired disease is entirely the murine variety and probably has been so almost entirely since 1922 or before. Within the last few years a larger proportion of the cases than previously have occurred outside the cities

of Los Angeles and San Diego, indicating that the rats in rural areas are acquiring a high incidence of infection.

The State of California and many of its cities, with the coöperation of the United States Public Health Service, have carried on efficient rat control programs for the control of plague for many years. This has undoubtedly been responsible for the relatively small number of cases of endemic typhus which have occurred, for the postponement of the increase of cases in California beyond the time when the increase in Texas and the southeastern states began, and for the present confinement of cases to the southern part of the state. The reasons for the recent increase in Los Angeles and San Diego and the spread to rural areas are probably an increase in the proportion of rats infected with typhus, and an increase in the proportion of rats infested with the so-called tropical rat-flea, *Xenopsylla cheopis,* one of the most efficient vectors of murine typhus[7] as well as of plague. This species of flea has been found on rats in most localities where it has been sought in connection with cases of endemic typhus. Within recent years it has been found in a number of northern cities in the United States.[11] Since the only possible control of the flea is through the control of the rat, it is probable that the only method of preventing a further increase of endemic typhus in man and its extension to other cities and rural areas is through more intensive rat control measures. Rat-proof construction of new buildings, supplemented by the relatively inexpensive methods of vent stoppage and elimination of rat harborages in old buildings, developed by the Georgia State Department of Health[12] and the United States Public Health Service,[13] will probably be required in order to reduce the rat population to a point where endemic typhus in man will rarely occur.

SUMMARY AND CONCLUSIONS

1. An analysis is presented of the occurrence of endemic typhus fever in California. The disease to date has occurred almost entirely in the southern portion of the state, the chief endemic areas being Los Angeles and San Diego Counties, and particularly Los Angeles and San Diego cities.

2. The locally acquired disease is the murine type and has probably been so almost if not entirely since 1922. This is indicated by the sudden disappearance of the disease in 1925 following the vigorous rat-control campaign in Los Angeles in connection with the epidemic of pneumonic plague. It is also indicated by the seasonal, sex and occupational distribution of cases, the low case fatality rate and the general absence of human lice on patients.

3. The recent occurrence of a larger proportion of cases in rural areas, particularly associated with hog ranches and race tracks, suggests that the disease in rats is becoming more prevalent in rural areas.

4. Although the incidence of human cases of murine typhus in California is not yet alarming, its increase in recent years emphasizes the necessity for the continuation of vigorous rat-control measures in the cities and thickly populated rural areas of southern California, and also in cities farther north which may become endemic foci in the future.

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MADUROMYCOSIS OF THE ANKLE

REPORT OF CASE

Lt. Comdr. David A. Wood (MC), USNR
Treasure Island

IN North America Maduromycosis (Madura foot, mycetoma) has been a rare and little-known disease, in contrast to India and the Dutch East Indies where it is prevalent and well-recognized. Because (larger) numbers of men from the United States will be exposed to infection by the fungi which give rise to Maduromycosis, it seems appropriate at this time to report a case recently seen in a U. S. Naval Hospital.

REPORT OF CASE

R. R. R., CK3c, Filipino, aged 40 years. Entered hospital, Oct. 25, 1943.

Complaint: Swelling inner aspect of left ankle, seven months.

Past History: Born in Philippine Islands. Lived on the Island of Luzon until 16 years of age, in the Hawaiian Island until 18 years, and in the United States since, except for the past ten months which have been spent in the Alaskan area. No recent illnesses or operations.

Present Illness: About seven months ago the patient first noticed a small nodule on the inner aspect of the left ankle just below the internal malleolus. Two months later it broke down and discharged with subsequent healing of the skin. The mass has increased rapidly in size and at present is about 7 cms. in diameter.

Physical Examination: T. 98.4°F., P. 74, R. 18, Bl. Pr. 116/74. Examination is essentially negative except for the left ankle. Here there is a nodular mass situated in the subcutaneous tissue, with no changes in the overlying skin. It is well circumscribed, and freely movable except for slight adherence to the deep fascia. No inguinal lymphadenopathy. An x-ray film shows a soft tumor overlying the internal malleolus with no bone changes evident.

Laboratory Studies: Blood: Kahn—negative. R.B.C.—5,370,000; Hgb.—15 grams; W.B.C.—5,900. Urine: Negative.

Course: Operative excision of mass was performed on Oct. 29th, under spinal anesthesia. The mass was attached to the fascia over an area 4 x 5 cms. At operation, the tumor appeared slightly lobulated, nonencapsulated, and solid. (Clinical diagnosis, "D.U. (Fibroma, left ankle)").

Surgical Specimen Report: Gross specimen consists of an elipse of skin 6.8 x 1.8 cms. which covers on one aspect a subcutaneous mass 6.5 x 3.5 cms. in size and 1.5 cms. in thickness. Upon cut section, the latter consists of islands of fatty yellow tissue surrounded by strands of tough grayish white fibrous tissue. The freshly-cut surface reveals numerous small yellowish areas of necrosis measuring up to 0.5 cms. in width, which centrally contain tiny black granules (Figure 1). *Histological examination* shows numerous subcutaneous abscesses containing not only a myriad of polymorphonuclear leukocytes, but occasionally large mycelial masses of closely-grouped fungi (Figure 2). About the periphery of the "granule" there is considerable dark brown pigment, contained within the fungi. Within the "granule" also are interwoven filaments, hyphae, and conidia (Figure 3). The histological diagnosis is "Maduro-mycosis, subcutaneus tissue, ankle, melanoid variety, (Madura foot)".

Bacteriological Studies: Inasmuch as the tumor was considered to be neoplastic, the specimen was fixed in formalin, thus precluding cultural studies. Exuding serum from the wound, cultured on the first postoperative day, showed no fungus growth.

Postoperative Course: Exuding serum cultured Oct. 30th, revealed no growth of either bacteria or fungi.

Potassium iodide, ggts. x, t.i.d., was given for one week, followed by sulfathiazole, gr. xv q 4 hours, for one week. By November 5th, the wound had healed per primum, and the patient was subsequently returned to duty as cured.

DISCUSSION

In 1933, Gellman and Gammel[1] published a table of nine authentic cases of maduromycosis reported in the United States, all but eight having been recorded since 1921. Essentially, the disease is one of tropical and subtropical countries, although sporadic cases have been recorded from both American continents, Europe, and Africa. Maduromycosis is endemic in India where a large majority of the cases involve primarily the feet. The organisms responsible for the disease are believed to be distributed mainly in the soil. It is of interest to bear in mind that India is largely an agricultural country, and to note that most of



Fig. 1.—Cross-section of mass removed from ankle. Note the multiple subcutaneous abscesses containing black ("melanoid") granules.

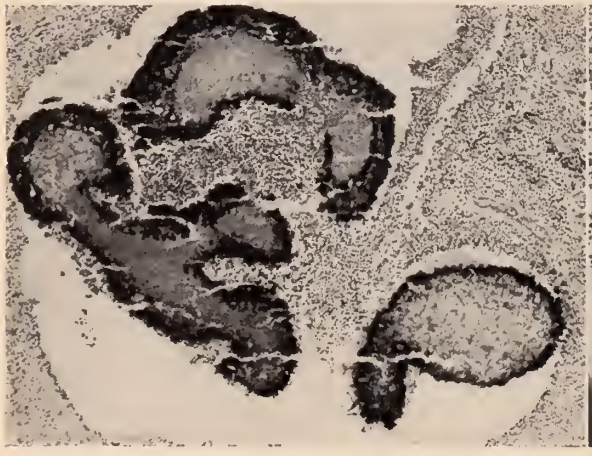


Fig. 2.—The mycelial mass of fungi constitute so-called granules which peripherally are pigmented. The fungi are contained in an abscess which also contains numerous polymorphonuciear leukocytes. (x100).



Fig. 3.—Same as figure 2. The "granule" or mycelial mass shows a prominent peripheral zone of pigmentation, and consists of interwoven filaments, hyphae, and conidia. (x400).

the cases reported from India[2] are found in the working-class population who do not have the protection afforded by shoes. It is believed that the association of injuries, noticed or unnoticed, of the bare feet with the causative fungi in the soil accounts for the frequency of infection of the feet. In 1846, the name "Madura foot" was first used by Colebrook[3] of the Madura Dispensary in India, to designate a disease of the feet which was prevalent in that geographic region. Discovery of fungi as the etiologic agents awaited the study of Vandyke Carter[4] in 1860 and introduction of the term "mycetoma" (fungous tumour). For a time actinomycosis was confused with maduromycosis and frequently referred to also by the term "mycetoma." Since Bollinger's[5] discovery that the higher filamentous bacteria, actinomyces (ray fungus), constitute the etiologic agent for actinomycosis, various studies have shown quite conclusively that even though a rather wide range of species may be responsible for any given case of the two diseases, maduromycosis is caused by more complex organisms, namely moulds belonging to both the fungi imperfecti and the acomycetes. Thus, maduromycosis is caused by any one of a variety of moulds.

Clinically, actinomycosis and maduromycosis are quite similar in many respects. Both are productive of abscesses containing "granules" which consist of dense masses of the etiologic organism. In actinomycosis the abscesses contain the characteristic "sulphur granule," in contrast to maduromycosis where the granules may be either black (melanoid) or light yellow (ochroid). Microscopically, the actinomycotic granule shows the characteristic formation of "clubs" on the distal ends of the ray-like filaments, whereas in the granule of maduromycosis one is able to identify poorly-staining hyphae, chlamydospores, and conidia. Depending upon the variety, melanoid or ochroid, there may or may not be peripheral pigmentation of the mycelial mass comprising the granule.

In 1943, Shaw and MacGregor[6] reported a case due to Monosporium Apiospermum, and cited the paper by Gammel[7] in 1927 where nineteen species of moulds belonging to both the fungi imperfecti and the ascomycetes are listed as having been identified as etiological agents in reported cases of maduromycosis. For the purpose of review, Gammel's list is quoted as follows:

Fungi imperfecti:

Genus Madurella	8
" Indiella	3
" Glenospora	2
" Scedosporium (Monosporium)	2

Ascomycetes:

Genus Allescheria	1
" Aspergillus	1
" Sterigmatocystis	1
" Penicillium	1

It is further of interest to note that in the above series black granules were found in those cases where the etiologic agents were Madurella Americana, Madurella ikedai, and Aspergillus nidulans.

The onset of maduromycosis is insidious, its course is slow, and progress is by extension. In contrast to actinomycosis which pursues a more rapid clinical course, and which responds to sulfa-therapy, maduromycosis is still resistant to chemo-therapy, and is best treated by early diagnosis and complete surgical excision.

SUMMARY

1. A case of maduromycosis of the melanoid variety is reported, involving the left ankle of a Filipino forty years of age.

2. The mycotic lesion had been present for at least seven months. Early in its course the overlying skin had ulcerated for a short time, but subsequently healed.

3. Upon surgical dissection the lesion was found to be circumscribed and subject to complete excision. No distant lesions are evident.

4. Etiology is briefly discussed.

U. S. Naval Hospital.

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MEDICAL EPONYM

Sudeck's Atrophy

Dr. Paul Sudeck (b. 1866), professor of surgery at Hamburg, was the author of a paper, "Ueber die acute entzüundliche Knochenatrophie [Concerning Acute Inflammatory Atrophy of Bone]," published in the *Archiv für klinische Chirurgie* (62:147-156, 1900). A portion of the translation follows:

"The . . . bone atrophy that occurs in association with acute inflammatory affections of the bones and joints occupies a special place in my opinion, and is essentially different from the simple atrophy of disuse. In the latter, for example, atrophy occurs to any considerable extent only if the functional stimulus has been lacking over a long period of time,—at least a few months,—whereas in what I have referred to as acute inflammatory affections of the bones and joints a significant degree of atrophy takes place in a remarkably short period of time, not only indeed in the bones directly involved, but also in the neighboring bony structures that are functionally related to the diseased bone."—R. W. B., in *New England Journal of Medicine.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

*Minutes of the One Hundred and Ninetieth (190th) Meeting of the Executive Committee of the California Medical Association**

An informal meeting of members of the C.M.A. Executive Committee resident in San Francisco, was held in San Francisco on Wednesday, January 31, 1945, at the noon hour.

(By mail vote, the minutes which follow received approval by all members of the Executive Committee.)

1. Roll Call:

Present: Drs. John W. Cline, Chairman; Philip K. Gilman, Council Chairman; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; and Mr. Clem Whitaker of the firm of Clem Whitaker and Leone Baxter (California Feature Service).

2. Proposal to Print and Mail Informative Bulletins Concerning Pending Compulsory Sickness Insurance Bills Before the California Legislature, to All Members of the California Medical Association:

Council Chairman Gilman called attention to the desirability of printing a weekly or bi-monthly bulletin to be mailed to all C.M.A. members, such bulletin to present up-to-date information concerning sickness insurance and associated medical practice and public health legislation that has been submitted to the 56th California Legislature now in session.

After discussion, it was agreed that it was very important that a definite program should be maintained through which would be brought to the attention of every member of the California Medical Association, the importance of the issues at stake in the compulsory sickness insurance and other legislation now pending.

It was agreed that this bulletin should be put out by the C.M.A. central office in line with action taken at the meeting of the Executive Committee held on January 21, 1945, whereby a special coördinating and liaison subcommittee for the C.M.A. Committee on Public Policy and Legislation was authorized.

3. Discussion of Publicity From a Technical Standpoint:

Mr. Clem Whitaker of San Francisco, representing his firm of public relations agents, was requested to give his opinion concerning the pending legislation.

Mr. Whitaker gave a presentation of his observations of the compulsory sickness insurance legislation, in relation to political and other forces, as based on his former experiences with such projects.

It was agreed that the firm with which Mr. Whitaker is connected should be employed to work in conjunction

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

with the special C.M.A. coördinating committee on legislative activities, as supervised by the C.M.A. Committee on Public Policy and Legislation and its representatives.

Considerable comment was made on certain technical phases of publicity and public relations, and it was agreed that the suggestions submitted should be carefully considered, and if deemed advisable, put into action.

4. **Adjournment:**

There being no further business, on motion made and seconded, it was voted to adjourn.

JOHN W. CLINE, M.D., *Chairman.*
GEORGE H. KRESS, M.D., *Secretary.*

OFFICIAL NOTICES

PROPOSED AMENDMENT TO CONSTITUTION

(Presented at Los Angeles by Lowell S. Goin. For reference, see CALIFORNIA AND WESTERN MEDICINE, for June, 1944, page 297.)

Re: Past President

Resolved, That the Constitution and By-Laws of the California Medical Association be amended as follows:

In Section 1 of Article VII delete the words "Past-President";

In Section 8 of Article VII delete the words "Past-President";

In Section 1 of Article X delete the words "Past-President";

In Section 2 of Article X delete the second paragraph reading as follows:

"At the expiration of his term of office the president shall become the past-president and serve as such for a term of one year thereafter, or until his successor assumes office."

In Section 4, Article X delete the words "Past-President":

* * *

PROPOSED AMENDMENT TO CONSTITUTION CONCERNING RETIRED MEMBERS

(Presented at Los Angeles meeting of the House of Delegates by C.M.A. Council. For reference, see CALIFORNIA AND WESTERN MEDICINE, for June, 1943, on page 349.)

Amend Article IV, Section 1(c) of the Constitution of California Medical Association:

The Section 1(c) of Article IV of the Constitution of the California Medical Association is hereby amended by adding, immediately after the first paragraph contained in said section 1(c), a full new paragraph:

If an application for retired membership is submitted by a competent medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1(c) of Article IV will therefore read:

(c) Retired Members:

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

Then follows the portion before read, the provision being made therein, Mr. Speaker, to make it possible for the Council to act upon these applications. Many of these applications are submitted in January and February of a succeeding year. Under the present By-Law, applications can be considered only when the applicant has active membership. In any calendar year, if dues are not paid on or before April 1st, active membership then ceases as of date of April 1st.

* * *

PROCEDURE CONCERNING AMENDMENTS TO C.M.A. CONSTITUTION

ARTICLE XV.—AMENDMENTS

Section 1.—Procedure to Amend Constitution

Any member of the House of Delegates at any meeting of any regular annual session thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the Secretary and shall thereafter be published at least twice in separate issues of the official journal of this Association prior to the next regular session of the House of Delegates.

At the said next regular session of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that annual session, and if two thirds of the Delegates present and voting vote in favor thereof, the same shall be adopted.

CHAPTER III

RE: COMPULSORY HEALTH INSURANCE BILLS PENDING IN 1945 CALIFORNIA LEGISLATURE (56TH SESSION)

CALIFORNIA AND WESTERN MEDICINE for January, 1945, on pages 1-4 and 25-40 presented informative comments and items dealing with proposed Sickness Insurance laws for California.

In the issue of February, on pages 51-53 and 64-92 the items were continued as Chapter II of the series.

In the present number of CALIFORNIA AND WESTERN MEDICINE the sequence is continued as Chapter III. (See pages 124 to 136.

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INDEX OF SICKNESS INSURANCE ITEMS

Pages 123 to 124

(The index of "Chapter I" of Sickness Insurance items, appeared in CALIFORNIA AND WESTERN MEDICINE, for January, on page 40. The index of "Chapter II," appeared in the February issue, on page 64. What follows, is Chapter III.)

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ITEM I

Governor Warren's Program—How Does He Get That Way?

If you count the next part of the legislative session as a battle—and it promises to be one of the biggest in State history—this month of February becomes the critical period of consolidating lines, amassing supplies, preparing to pass the ammunition. The undramatic period civilians are apt to dismiss as "phony war." Don't mistake it. The issue of Governor Warren's program rests largely on what supplies and strength, what civilian interest as well as "pressure group" interests are aroused during the next four weeks.

Few legislative interims have been as important to Californians; for few governors have proffered a program that means so much, so intimately, to the millions of private citizens.

Governor Warren has chosen the field of battle and picked his own position on the terrain. Others at Sacramento had some of the same points in mind. But he got there "furstest"; whether he has the "mostest" remains to be seen.

The Governor sketched a large program—prepaid medical care; expanded unemployment insurance; improved and speeded workmen's compensation; new department of mental hygiene. . . .

These, together with disposition of taxes and surplus funds and a highway program, will be the main objectives in the coming political battle.

And the question in many minds is—how did Earl Warren, national Republican figure who keynoted the G.O.P. convention and turned down the rôle of vice-presidential candidate, become the general of such forces, the leader on such issues? How did an Alameda district attorney, nurtured in conservative Republicanism, a G.O.P. attorney general, become in a few years the champion of a "peoples' program."

There is a jibe in Sacramento that Governor Warren found his January 8 speech in some desk drawer left over from the Olson Administration. Democrats complain that he lifted more than half their party platform. But they came around to promising support.

"The program contains principles we have advocated for years," said William Malone, Democratic state committee head. "We certainly won't oppose them just because Governor Warren offers them. We'll be there fighting for them."

There are strange paradoxes in California's political situation. The State is preponderantly Democratic in registration and voting strength. But the State Administration is Republican, the majority in both legislative houses is Republican. This would suggest that a Republican governor should be able to get what he wants, especially when he offers a program to answer a popular need.

Yet Republicans have not made a commitment of support. Many in the Legislature are confused. They are astonished at such legislation emanating from a Republican source. They were unprepared for such liberal philosophy. They are suspicious that Governor Warren has in mind only his own political future, and is making a bid for popular support by mimicking demands of the powerful C.I.O. They are uncertain whether to credit his audacious proposals to political expediency; or to concede that they may be an accurate interpretation of what people want.

And into the Legislature's attitude towards the Warren program enters another element. Party affiliation actually means less in that body than individual staying power. Through power of one sort or another, through ambiguous cross-filing, through close attention to community needs, many men have stayed in the Legislature a long stretch of years. Even now districts which went for Roosevelt in the national election returned men with reactionary voting records to the Legislature; districts which voted for Governor Warren three years ago have done the same.

Governors, on the other hand, have pretty short terms in California. For more than 30 years, no governor has been returned for a second term. Men who have sat through the Legislature 10 and 20 years have seen Republican governors come and go. There are many such perennials in the Senate, quite a few in the Assembly, and most are powerful. They are accustomed to great independence towards the State executive. They can and often do turn thumbs down on a Governor's program, especially in the second session. They assume it to be his last.

Governor Warren's program is unlike those which Republican governors have been accustomed to offer since Hiram Johnson's time. Tax adjustments, budget refinements, technical administrative improvements were the main achievements of the G.O.P. governors who succeeded each other since 1917. Only Democratic Governor Olson asked legislation on such popular measures, but he did not win a sympathetic hearing. He was incapable of giving his program leadership.

How did Governor Warren "get that way"?

If he has taken some orientation from the aims of that lone Democratic Administration, it has probably come through Atty. Gen. Kenny, a Democrat but avowed supporter of Governor Warren's "non-partisan" approach to State politics. He keeps close to Governor Warren on an "exchange of ideas" basis.

In addition, Governor Warren probably knew before he drafted his speech that prepaid health insurance, as well as increased unemployment insurance coverage, and some "fair employment practices" committee were to be "do or die" issues with the C.I.O. He knew, and he took the ideas. But he moderated them.

He has managed to incorporate into his own program practically all of the important demands of the hour. Politics or perspicacity? Which ever, the people stand to benefit.

In seeking to explain the Governor's interest in a "peoples' program" some credit his sense of responsibility as the father of a large and never very affluent family. Many times Governor Warren's discussion of some public issue has been in terms of a "family man." In a discussion of women's working hours on one occasion, it was evident he thought in terms of the energy of his own daughters, and the protections they would need. In explaining the need for health insurance he once remarked, "I know I would have appreciated such protection for my family." This attitude may contribute somewhat to his promotion of a popular program. At least it gives a tone of deep sincerity.

There are very few in Sacramento unconvinced that the Governor is personally back of his own proposals. His candor when he says "I know the people need health insurance" is apparent. He promises to battle through to victory.

As one department head put it, "He feels it way down

deep. He has convinced himself and he is out to convince the world. He has hit the sawdust trail."—Mary Ellen Leary, in San Francisco *News*, February 7.

ITEM II

Huge Medical Program Proposed to United States Senate

Washington.—(UP.)—This country has been neglecting its health for years—witness the nearly 9,000,000 men of military age who are unfit for military service—and a Senate subcommittee proposed today that something drastic be done about it as soon as possible.

It proposed a gigantic, multi-billion-dollar health and medical-facilities program to be worked out now and put into effect "as soon as materials and labor become available" in the reconversion period.

The program, involving close federal-state coöperation, would reach into every community in the nation and would make available to all citizens not only curative medical care but also preventive and diagnostic services now lacking or inadequate in many sections and levels of society.

Proposals Made

The proposals were offered in an interim report by the Senate subcommittee on wartime health and education on the basis of findings assembled at hearings during the last year. The subcommittee, headed by Sen. Claude Pepper, D., Fla., heard scores of witnesses representing the U. S. Public Health Service, the American Public Health Association, the American Medical Association, the Army and Navy, and the selective service system.

Recommendation No. 1 is for Federal grants-in-aid to states now to assist in postwar construction of hospitals, medical centers, and health centers in accordance with State plans approved by the public health service.

This program for what the subcommittee called "a coördinated network of medical centers" in states and communities would involve intial expenditure of $2,000,000,000 for construction and supplies, according to testimony by Surgeon General Thomas Parran.

Proof Submitted

The subcommittee cited as proof of the need for such a program the following data assembled during its investigations:

1. More than 23,000,000 Americans in 1935 had a chronic disease or a physical impairment.

2. Illness and disability cost the country more than 600,000,000 man-days a year.

3. From Pearl Harbor to Jan. 1, 1944, job accidents took the lives of 37,600 U. S. workers, 7,500 more than the military dead for the same period.

4. About 4,500,000 young Americans have been classified 4-F. In all, the subcommittee said, "it is estimated that at least 40 per cent of the 22,000,000 men of military age—between 8,000,000 and 9,000,000—are unfit for general military duty."

Public health estimates, the subcommittee said, show that the nation needs facilities for 100,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds.—Santa Ana *Register*, January 4.

ITEM III

Health Insurance Answers Sought

Assembly Group to Hold Hearings on Bills Before Legislature

When the public health committee of the Assembly begins a series of hearings next week on proposed State health insurance legislation it will seek the answers to questions raised in connection with the half-dozen measures on the subject pending before the Legislature.

Chairman Fred Kraft of San Diego has announced the opening session for the committee at San Diego next Tuesday. The committee will hold a three-day hearing in Los Angeles beginning February 15.

Programs Presented

Health insurance measures before the Legislature include one sponsored by Governor Warren, one presented at the request of the California Medical Association, another backed by the C.I.O., and a series of bills presenting the views of the California Farm Bureau Federation. There are others.

There are several general questions common to all State health insurance proposals that will be answered by the Legislature:

Should we have State health insurance at all?

If we have it, should participation by the individual be on a voluntary or compulsory basis?

Who should pay and how?

What services shall be rendered the insured?

If we have compulsory State health insurance, what becomes of the estimated more than a million persons in California already covered with health insurance either through policies which they purchased from the regular insurance companies or through some form of group insurance?

Have Varying Ideas

Those are a few of the main questions the people will want the answers to before they commit themselves on the issue: Do you favor State health insurance?

Already members of the Legislature have found that individuals have widely varying ideas of what State health insurance can or will do for them. Some of the lawmakers are sending out postcards to find what their constituents want in the line of health insurance. . . .—Chester G. Hanson, in Los Angeles *Times*, February 7.

ITEM IV

C.I.O. Health Bill Analyzed

Union-Backed Plan Goes Beyond Warren Idea in Some Phases

The compulsory State health insurance measure backed by the C.I.O., Assembly Bill 449, is, in objectives and general terms, like that urged by Governor Warren, but is more extravagant in some of its detailed provisions.

This bill would cover all those employees who are covered by State unemployment insurance, as would the Governor's bill, but it goes farther and includes all persons who are receiving State aid, such as old age pensioners. It would include unemployed persons and make them eligible for benefits not only for the year in which they are paid up but for a year after. It also will include persons receiving Federal aid in any form when appropriate Federal legislation is passed. Employees of the State, cities and counties also would qualify. . . .

In one very important particular the C.I.O. bill differs from the Governor's bill: it calls for payments to be made to the doctors on the per capita basis, except as to special services and laboratory work where the fee system would be used. That is, a doctor agrees to care for patients at so much a head for a given period of time. The Governor's bill calls for the fee system all the way around. The C.I.O. bill, in addition, will distribute among the doctors those persons who have not selected their own doctor in "due time," a chore to be done by an area medical director.

A spokesman for the C.I.O. said their bill will provide for group insurance participants. That is, such groups that have their own laboratories and plant, clinics and the facilities to serve their patients may qualify with the commission. But mere associations of doctors giving a service as individual doctors, could not qualify, said

the spokesman. The individual would be subject still to the 1½ per cent pay check deduction.

Periodic physical examination would be given under the terms of this bill but not in the Governor's bill. That, of course, brings up the question of what the examination is to consist and how much will it cost—a matter seemingly left for the commission or board of doctors to set forth.

The bill calls upon the commission to study ways and means of bringing farmers, agricultural labor, self employed and all others under the provisions of State health insurance—Chester G. Hanson in Los Angeles *Times*, February 8.

ITEM V

Doctors' Health Bill Analyzed

Financial Inducements Proposed to Encourage Voluntary Joining

The California Medical Association is sponsoring Assembly Bill 1200, which proposes health insurance on a widely different basis from that proposed in other measures.

The doctors propose that instead of making State health insurance compulsory, certain financial inducements be held out to the individual to encourage him to join some form of group insurance or approved health or hospital prepayment plan.

They propose to let the individual use his unemployment insurance payments, in part, and any benefits he may be entitled to, to help pay his doctor bills.

Voluntary Basis

They place participation in such plans on a voluntary basis. If you don't want such insurance you don't have to take it. However, even though a person does not participate in one of the approved group or prepayment plans he shall be entitled to use his unemployment insurance benefits to help pay his doctor or hospital bills under certain conditions.

Other health insurance bills before the Legislature, including that sponsored by the Governor and that by the C.I.O., excepting the Farm Bureau bills, require the individual to participate in the payment of premiums whether he wants the insurance or not (except those declining on religious grounds.) In short, they take it off your pay check and you can use the service the way they propose to give it to you or not.

At present the employee now contributes by way of deductions from his pay check 1 per cent of the first $3,000 of his salary into the State unemployment insurance fund. The doctors' bill proposes that if an employee now under unemployment insurance joins an approved nonprofit hospital care plan his contribution to the unemployment insurance fund shall be reduced by 15 per cent. If he joins a medical care nonprofit plan his contribution would be reduced by 35 per cent. If he joins a plan that embraces both medical and hospital care approved by the State his contribution to unemployment insurance would be reduced by 50 per cent.

Rebate to Pay Care

It is assumed he will use his rebate to help finance his payment on his prepaid medical and/or hospital care plan. This is money that tens upon thousands of employees pay into unemployment insurance funds from which they draw no cash benefits.

The doctors go further in their bill; they propose that if the employee joins no prepaid medical or hospital care plan and becomes hospitalized from illness he then may draw whatever unemployment insurance benefits he would have been entitled to if he had become unemployed. At present he cannot use illness as a reason for drawing unemployment insurance.

What the doctors are saying is: Let's use unemployment insurance premiums and benefits to help out on health insurance. You are free to buy whatever type of health insurance you want and can pay for, or you don't have to buy any and you can still use unemployment insurance benefits for "sickness benefits."

The bill sets up conditions under which sickness benefits can be taken out of unemployment insurance; such as, the employee must be hospitalized for a waiting period of four days,, his illness or injury is not caused by his employment (which would be taken care of by workmen's compensation, presumably), and he must be under care of a licensed physician or surgeon.

Regulations Proposed

As in the other bills, rules and regulations are set up governing the membership and operation of the group medical or hospital care and the contracts. No new tax is proposed in this bill, either on the employer or the employee.

The doctors point out that objection to reducing employees' contributions to unemployment insurance in California is not well grounded because the fact is that California is one of only four States that require the employee to contribute to unemployment insurance and that all the other States seem to get along all right on the payments the government allows the unemployed.—Chester G. Hanson in Los Angeles *Times*, February 9.

ITEM VI

New Bill Held Health Insurance Compromise Move

Sacramento, Feb. 11.—Although the main author denies it's intended as an alternative to Governor Earl Warren's health insurance bill, a certain bill introduced in the State Senate by members of an unemployment insurance committee looms as a likely compromise for the anticipated controversies on health insurance.

The bill, SB 1802, sets up a fund from compulsory employee contributions to provide benefits to individuals unemployed because of sickness or injury for which no compensation is made under the unemployment insurance or workman's compensation law.

Purpose of SB 1802 is to compensate in part for wage loss sustained as a result of sickness or injury, rather than to relieve the individual of the burden of medical bills.

Alternative Aim Denied

State Senator Jack Shelley of San Francisco, chairman of the committee and main author of SB 1802, denies that the measure was intended as an alternative to Governor Earl Warren's health insurance bill, of which Shelley himself is a coauthor.

However, Senator H. E. Dillinger of Placerville, who is likewise a coauthor of both SB 1802 and the Governor's health bill, says he wouldn't be surprised if the former turns out to be the nearest thing to a health insurance bill to emerge from the 56th session of the Legislature. . . .—Peggy Ferris in San Jose *Mercury Herald*, February 12.

ITEM VII

Labor States Health Views

San Diego, Feb. 13.—Representatives of organized labor today told members of a California Assembly committee that they were 100 per cent in back of any legislation that will offer the working man hospitalization and medical care "without resorting to assembly-line methods."

The committee is conducting a series of hearings throughout the State on the controversial assembly bill that would provide medical services and be financed by a withholding tax.

Speaking for the bill at the opening session were Robert Noonan, secretary-treasurer of the San Diego County Federated Trades and Labor Council; N. R. Pyeatt, president, Aeronautical Machinists (A.F.L.) and Ray Morkowski, of the United Automobile Workers (C.I.O.).

"It has long been our contention that the average employee is not financially able to provide adequate medical care for himself or his family. Only the wealthy and destitute are getting the best of medical care," Mr. Noonan said.

Mr. Noonan said he did not advocate any particular bill, but an acceptable measure should do the following:

1. Cover everybody who might be unable to provide care for himself and family.
2. Offer the best available service, flexible enough to allow individual treatment without resorting to assembly-line methods.
3. Provide much-needed preventative diagnosis and treatment.
4. Go beyond present private insurance.
5. Not be patterned after the "California Physicians' Service."—San Francisco *News*, February 13.

ITEM VIII

Health Plan Gets U. S. Eye

Senator James E. Murray (D., Mont.), coauthor with Senator Robert Wagner (D., N. Y.) of a bill for a Federal system of prepaid health insurance declared today, in an exclusive statement to *The News*, that the pattern of health insurance adopted by California "is likely to have far-reaching influence on what happens in other states."

The senator made clear that he hopes for a national system of health insurance—part of a "unified and comprehensive system of social insurance." His and Senator Wagner's "cradle to the grave" bill provides for prepaid medical insurance plus unemployment insurance and old-age insurance.

Senator Murray, in his statement, revealed for the first time that the revised form of this "cradle to the grave" bill, soon to be introduced, will "clarify the relationships between the Federal and State Governments in the administration of the health benefits."

"We intend," he said, "to make it even clearer than it was in our first bill that a state or a state agency can become the administrative branch of the national insurance system, responsible for providing the health benefits to the people of the state.

"The coverage and financing would still be national; the administration of the benefits—that is, the arrangements to provide medical services—would be state and local, within the framework of national policies and standards."

As his remarks reached here, the first public hearing on proposals for a state prepaid medical health plan opened at San Diego. Members of the Assembly public health committee, headed by Assemblyman Kraft (R., San Diego), will be in Los Angeles later this week, then hold further hearings in Fresno. They will have a two-day session here March 2 and 3.

Panel Discussion

Meanwhile, the Palo Alto Democrats Club set for tomorrow night at 8 a panel discussion of health insurance by the following speakers: Senator John Shelley, San Francisco; Senator Byrl Salsman, San Jose, on the Governor Warren bill; Dr. Stanley Kneeshaw, member of the California Medical Association state council, and John Hunton, association executive secretary, on the physicians' bill; Dave Hedley, on the C.I.O. bill. It will be held at the Palo Alto Women's Clubhouse, open to the public.

At a public forum in San Francisco Sunday, Feb. 25, the Lawyers Guild will be cosponsor with the Northern California Union Health Committee, the Physicians Forum, the California Department of the Veterans of Foreign Wars of the United States, the Mental Hygiene Society of Northern California, and the California Conference of Social Welfare.

One question raised about the state proposals has been the possibility of meshing it with any future Federal plan. The present Wagner-Murray bill has a "contract" clause, permitting a state setup to handle operation under broad Federal standards and organization.

While the Federal proposals have been used by some to discourage adoption of a state system, others argue that such programs could be better administered from the state capitol than the national capitol.

California Outstanding

He pointed out that a number of states have health insurance bills before their legislatures, but added:

"California is outstanding in giving serious attention to such bills. If one of the bills or some combination of bills should be enacted the pattern that is adopted in California is likely to have far-reaching influence on what happens in other states."

Senator Murray emphasized that his comments are not to be construed as interfering in a situation "primarily or exclusively a concern of the people of California."

His statements were directed "to the point that the present discussions in California are of substantial interest and importance to other states and to the nation as a whole."

The need for health insurance, he remarked, is very great.

"The public is overwhelmingly in favor of it, as public polls plainly show. The principal labor organizations of the country are strongly for it; and they have again and again expressed labor's readiness and willingness to pay contributions into an insurance fund in order to have protection against the costs of adequate health services.

Rearguard Action

"The American Medical Association and its political stooge (the National Physicians' Committee) are merely fighting a rearguard delaying action. I suspect they are hoping that if they can have health insurance come slowly enough and with enough muddling, it won't amount to anything when it is adopted and they will be in control of it.

"The doctors," Senator Murray went on, "have a proper rôle to play in the administration of health insurance, and any good plan will give them that rôle. The doctors will have to be the ones to furnish medical care, and every one wants them to have the best possible opportunity to furnish the highest grade medical care they can possibly give all their patients.

"At the same time, health insurance as a whole must be of the people and for the people; the basic and overall control of health insurance must, therefore, remain with the public and not with any limited or special-interest group."

He urged state study of the Federal bill (S. 1161, 1943), saying he considered it laid on "a sound pattern." Revisions now being worked into that "cradle to the grave" measure bring a number of improvements he

said, "suggested by the year and a half of public discussion."

Senator Murray concluded by expressing a hope that whatever legislation California may adopt on health insurance "will follow as closely as possible the general pattern of our national bill, and will contain broad and flexible provisions so that California's system can fit into the national program as soon as such a program is enacted."—Mary Ellen Leary in San Francisco *News*, February 13.

ITEM IX

California League of Women Voters

Mrs. Max Stern, 1238 14th Avenue, who has been serving as legislative advocate for California League of Women Voters, has been appointed one of the two new directors on the League's State board. Mrs. William Irvine, president of Salinas League of Women Voters, is the other director. Announcement of appointments and important policies adopted by the league was made at the State board meeting last week in Los Angeles.

A medical insurance system which could provide for full curative medical and sickness prevention services of the highest standard for every citizen of the State was urged by the board.

Wants Wider Scope

The board in adopting its policy decided that no measure now pending incorporates the wide scope of services, the protection of standards or the safeguards to individual freedom of professionals or beneficiaries to which the league is committed.

The league is pledged to work at the Legislature for the enactment of a law which will provide for:

1. Full medical services including periodic medical examination, immunizations, etc., on the preventive side, and general and specialized medical services, hospitalization, x-rays, drugs, dental services on the curative side.
2. Basic right of patient to choose doctor and of doctor to accept or reject patient, and of doctor to participate in or stay out of plan, and to choose the type of practice he favors.
3. Financing by contributory insurance payments from employers and employees.
4. Fees for payment only for specialists' services; a system of capitation payment for general medical services.
5. Adequate provision for impartial and efficient administration protected against control by any interested group.

Part-Pay Plan Approved

The league opposes any system of medical insurance which discourages prompt resort to medical help when necessary, such as the requirement that the patient pay for the first one or more visits, or for a part of the services. . . .—Sacramento *Union*, February 14.

ITEM X

Health Insurance Demand Debated

The first point in dispute as to the proposed State health insurance plan is whether the people of the State actually want prepaid health service. The fact that this point is brought up indicates the battle will be fought on four lines instead of three.

The three, as mentioned in this column two weeks ago, are:

Whether health insurance shall be compulsory or voluntary;

How the cost shall be distributed; and

How the doctors shall be paid.

Governor Warren, in his message, said: "We have ample evidence that our people desire this protection."

This statement is now under attack. A publicity man for the opposition says: "The only public demand for this costly program (Governor Warren's), so far as can be determined, emanated from a small section of the C.I.O."

Dr. Lowell S. Goin, president of the California Medical Association, asks why, if the people are so loudly demanding prepaid care, don't they come and buy it? Through the California Physicians' Service, he says, it has been available for seven years for less than the proposed payroll tax. They haven't bought it. Why pass a law to make them?—W. L. Blair in Pasadena *Post*, February 14.

ITEM XI

Doctor Assails Health Proposal

San Diego, Feb. 13. (AP)—Major opposition to the labor-endorsed compulsory health insurance was given here today by Dr. S. J. McClendon, representing the San Diego County Medical Society, before an Assembly committee conducting the first of a series of Statewide hearings on health measures.

Dr. McClendon testified that nearly a third of the State's physicians are now in the armed services and urged that no change be made in the fundamental laws concerning the medical profession until the war ends. He said the society would support all forms of voluntary health insurance.

Compulsory health insurance legislation is long overdue in the opinion of San Diego organized labor, Robert E. Noonon, secretary of the A.F.L. Central Trades Council, testified.—San Jose *Mercury Herald*, February 14.

ITEM XII

Health Insurance

Hearings to Begin on Voluntary and Compulsory Protection Bills

Proponents of the various health insurance plans will present arguments for their measures, both compulsory and voluntary, today at the first of a three-day series of hearings to be held at Los Angeles.

The hearings are being held by the Assembly Public Health Committee. The first of the Statewide hearings was held at San Diego Tuesday. San Francisco hearings have been set for March 2 and 3.

Governor Warren's office announced yesterday that no official representative of the Governor would present his compulsory health insurance bill, although it was possible that one of the authors who resides in the south might appear before the committee today.

John Hunton, executive secretary, and Howard Hazzard, attorney, will speak for the Northern California section of the California Medical Association, along with Dr. Lowell S. Goin, president, and Dr. Vincent Askey, both of Los Angeles. The C.M.A. is backing a voluntary health insurance plan.

Dr. T. Henshaw Kelly, secretary of the California Physicians' Service, which operates a voluntary system of prepaid medical care, issued a statement that at least $100,000 in State taxes would be required in addition to payroll deductions to maintain any compulsory health insurance system in California.

Dr. Kelly's statement was issued through the Public Health League of California by Clem Whitaker, publicist for the group of doctors who will campaign against the Warren plan.

"The experience of the California Physicians' Service in providing complete medical and hospital care for per-

sons living in war housing projects," said Dr. Kelly, "has demonstrated that the costs of such service average from $42 to $50 per person per year."

He contends that the 3 per cent pay roll tax provided in both Governor Warren's bill and the C.I.O. measure would be insufficient to meet the costs of a compulsory system. The payroll deductions should run between 5 to 6 per cent instead, he maintains.

Dr. Kelly states "persons now under unemployment insurance" had earnings in 1944 of about "five billion dollars, so that a 3 per cent payroll deduction tax on that amount would have yielded about $150,000,000.

But he says the contemplated care of 6,500,000 people "even at the low figure of $40 per person" would total $260,000,000 a year, making necessary a contribution from the State.

Statisticians for both Governor Warren and the C.I.O. claim the average cost of medical care has run between 3 and 4 per cent per family a year.

"It is undoubtedly significant," says Dr. Kelly, "that the Warren bill contains a provision, pledging 'the faith and credit of the State . . . to assume the operations of the system until June, 1949,' and some of the other bills provide for direct State appropriations to defray the administrative costs of the program."

Provisions of the Thomas bill, sponsored by the C.I.O., will be explained today to members of the public health section of the Commonwealth Club at its weekly Hotel St. Francis luncheon seminar.

Paul Pinsky, research director of the C.I.O., will discuss the bill. . . .

Pinsky said he would explain in detail the reasons why his group favors payment of medical services by the capitation, or per capita plan, rather than on a fee basis. Special services are to be paid on a fee basis out of a State medical insurance fund.

The Governor has expressed a preference for the fee system of payments.

Pinsky said estimates of the probable income from payroll taxes are now being made by his organization.

Robert Burrill, representing the C.M.A., will speak on "Compulsory Health Insurance" before the San Francisco chapter of the Controllers' Institute tonight at a Hotel St. Francis meeting.—Earl C. Behrens in San Francisco *Chronicle*, February 15.

ITEM XIII

Health Insurance Hearing

Opponents Charge Plan is a "Step Toward Socialism"; $100,000,000 Deficit Predicted If Program Passes

Los Angeles, Feb. 16.—Governor Warren's recommendation that the current Legislature enact a compulsory health insurance law was branded here today as "a step toward State Socialism" and as certain to cause an "immediate deficit of at least $100,000,000."

Paul Shoup, head of the Los Angeles Merchant and Manufacturers Association, made the charge to the members of the Assembly Public Health Committee, that the establishment of a system of compulsory health insurance was the "crossing line from the Republican form of government to a Socialistic or Communistic State."

As one of the spokesmen for the California Medical Association, Executive Secretary John Hunton, San Francisco, said enactment of a compulsory health act covering 6,500,000 persons, as is contemplated, would cost about $260,000,000 annually or almost $100,000,000 more than the proposed 3 per cent payroll tax would raise to finance the system.

Hunton also declared present inadequate hospital facilities would necessitate the expenditure "of $50,000,000 for improvements, etc., at existing hospitals" to take care of the people under the program.

This was opposition day at the hearing. Numerous speakers urged that further study be made before any action is taken.

Representatives of voluntary health and hospitalization programs, industry, builders, contractors, apartment house owners, as well as doctors, joined in asking for delay in the passage of any bill on the subject.

Dr. William F. Henry, speaking for the California Chiropractic Association, said his group was neither opposing nor supporting any of the bills before the Legislature. He asked that the chiropractors be included, however, if any compulsory health insurance act is passed. They are not now included in either Governor Warren's bill or that sponsored by the C.I.O.

The Los Angeles Chamber of Commerce, through Ronald M. Ketcham, declared opposition to any compulsory health plan, declaring to finance the anticipated deficit "would require that the present sales tax, for example, be tripled."

First to propose that further study be made of the problem came from Dr. E. Vincent Askey, speaker of the House of Delegates, executive body of the California Medical Association.

Dr. Askey said he spoke as a "private practitioner," who was opposed to "all of the compulsory health insurance bills" now pending before the Legislature.

Dr. Askey added spice to the hearing by charging that C.I.O. representatives, including Albee Slade, a witness yesterday, had sought to conceal from the people the cost of compulsory health insurance by providing for the payroll tax method of raising the funds to support the program.

The witness challenged statements by Slade that C.M.A. officials, conferring as individuals, had agreed upon a set of principles to be included in proposed compulsory health insurance legislation. Slade said there had been discussion at the conferences about the need for the establishment of a $200,000,000 fund by the State to start the health insurance system. But, Mr. Askey contended, the C.I.O. representatives had insisted that if the people knew of the need for setting up such a fund, they would "turn down" any legislation on the subject.

Dr. Lowell S. Goin, president of C.M.A., who preceded Dr. Askey before the committee, told of the conferences with the C.I.O. representatives. He said "we sent out scouting parties into the enemy's country" and discussed certain phases of the health problem.

"I offered a series of principles," said Dr. Goin, in testifying as to the conferences with Slade and others. He said these principles were the "very least that would be included."

Dr. Goin said that, however, "he never had, do not now and have no intention of supporting compulsory health insurance."

He said he believed the "overwhelming number of doctors in California are opposed to compulsory health insurance."

"It is our studied opinion," declared Dr. Glen D. Cayler, director of the public affairs department of the California Osteopathic Association, "that some plan providing a prepayment insurance on a compulsory basis is the only kind of a plan that can be successful, and should be worked out in coöperation with all interest in the groups and put into effect without undue delay."

John S. Selover, representing the Christian Scientists, told the committee he did not oppose any of the health insurance bills but only asked that in any compulsory

health insurance bills protection be given "the religious liberties of the Christian Scientists."

Opposition to Governor Warren's bill was expressed by William Penn, Los Angeles chapter, National Electrical Contractors' Association, because of "the payroll tax."

David G. Shearer, representing trucking interests here; C. C. Cashwell, secretary-treasurer, Building Material Dealers' Credit Association, and Dave Smith, general counsel, Motor Car Dealers' Association, all opposed the compulsory health insurance bills because of the payroll tax, 1½ per cent of which must be paid to the employer. —Earl C. Behrens, in San Francisco *Chronicle,* February 17.

ITEM XIV

Deficit of $100,000,000 Seen in Health Proposal

Medical Association Official Warns of Vast Costs at Legislative Hearing

Compulsory State health insurance, if enacted, would run into an immediate deficit of $100,000,000 the first year, the Assembly Committee on Public Health was warned yesterday.

The deficit prediction was made by John Hunton of San Francisco, executive secretary of the California Medical Association. He based it upon figures and experience tables from privately operated group insurance plans, particularly the California Physicians' Service, which handles about 300,000 patients a year.

In that system, he said, the doctors handle about 650 calls a year per 1,000 patients. This is on the limited coverage. The moment full coverage goes in the demand would jump to about 1,300 calls a year and if the children were added it would be about 1,790 calls a year per 1,000 patients, said Hunton. This is what is proposed in compulsory health insurance.

Care of 6,500,000

The C.P.S. estimates full medical and hospital and surgical care at a minimum of $40 a year a person. With 6,500,000 persons to be served in the State under the proposed compulsory plans, this would require $260,000,000 per year in the fund.

The unemployment insurance records show $164,000,000 a year coming in from the over-all 3 per cent unemployment insurance taxes, which is what the health insurance fund would net annually. This would leave the $100,000,000 deficit, assuming operating costs paid by the State. After the war, when employment drops, say to the 1941 level when the 3 per cent tax netted $80,000,000, the deficit would jump proportionately.

Ralph Walker, executive director of the Blue Cross in Southern California, said his organization, which gives insurance for hospitalizaton, favored the voluntary plan.

Doubts Readiness

There are 17,000,000 enrolled in the Blue Cross insurance plan in the country and in California about 250,000, said Walker. The enrollment is growing by 3,500,000 a year, he said. That is what the people want, he thought, protection against the heavy hospital bills in serious illness. He doubted the people are ready today to approve a law taxing themselves for health insurance. The organization experience shows that they can insure a family for their service at $2.60 a month, said Walker. . . .

Among organizations represented in opposition to compulsory health insurance at this time were commercial printers and wholesale paper dealers, the Apartment House Association, Southern California Restaurant Association, Downtown Business Men's Association, Los Angeles Chamber of Commerce (with a full report to be made in March at Sacramento), Los Angeles Painters and Decorators Association, Southern California Retail Grocers Association, California Hospital Association—with figures showing the hospitals could not even begin to care for the patients—the East Los Angeles Property Owners Association and others.

Sees Vast Costs

Earlier the committee was told that representatives in a conference with some doctors argued that if the people of the State were to be told right at the start that State compulsory health insurance would require $200,000,000 of tax money to get it going they would turn it down promptly. Thus, the C.I.O. men were represented as suggesting, it would be better just to finance the thing gradually by a total payroll deduction tax on employers and employees of 3 per cent.

Dr. E. Vincent Askey, speaker of the House of Delegates of the California Medical Association, made the statement about the C.I.O. proposal. He appeared before the committee in his capacity of private practitioner, he said.

Fights State Rule

Askey said he had no objection to a voluntary system of public health insurance.

"I do oppose," he said, "the constant intervention in my affairs by the State and I object to myself and others becoming the creatures of the State rather than the State being the creature of the people."

Askey said none of the bills offers real compulsory health insurance as there is no compulsion on the individual to see a doctor or would the doctor be required to sign up for the service. A person with venereal disease, for instance, would not be required under this bill to see a doctor.

Predicts No Wonders

Dr. Lowell Goin, president of the California Medical Association, also warned against what to expect even if compulsory health insurance laws were passed. Germany has had such laws for 60 years and England for about 35 years, and yet their records on health as to draftees is not as good as ours, he said.

This matter of the proponents saying how such a law would eliminate the very high rejections on the draft is nonsense, he said. They talked about 5,000,000 men being rejected. The fact is that that figure is not accurate and when you take out all those who suffered mental defects, those who were cripples, natural or accidental, those with defective vision, those with venereal disease, you wind up with about 1,500,000 rejected men—and it is questionable how much public health insurance could have done for them, he asserted.

For Voluntary Plan

Certainly something should be done along that line and that is why, Goin said, the Medical Association is sponsoring Assembly Bill 1200 which calls for such insurance on a voluntary basis, using funds from unemployment insurance, partially, to finance it. No new taxes. Medical science has no magic wand with which to prevent and cure disease.

Other opponents to compulsory State health insurance financed by payroll deductions included David Shearer, for the Trucking Industry, Inc.; C. C. Cashwell of the Building Material Dealers Credit Association, David Smith for the Motor Car Dealers Association and Warren Penn for the Electrical Contractors Association.—Los Angeles *Times,* February 17.

ITEM XV

Health Insurance

Fight by Warren Called the Only Way to Pass Bill

Los Angeles, February 18.—Unless Governor Warren

personally and vigorously enters the fight, and is able to influence both public opinion and the Legislature, there appears to be slight chance a compulsory health insurance act will be passed at the current session.

This becomes evident after public hearings by the Assembly Public Health Committee.

The committee spent three days here and one in San Diego, hearing from persons interested in health insurance. Further hearings will be held later in Fresno, San Francisco and Salinas.

Committee's Antagonism

It requires no occult powers to discern the antagonism of a considerable number of the Assembly Committee to any compulsory health program.

At the present writing there seem to be only three members of the committee, Assemblymen Gaffney, San Francisco; Hawkins and Massion, both of Los Angeles, who are for either Governor Warren's bill or the Thomas bill, sponsored by the C.I.O.

Two members, G.O.P. Floor Leader Collins, Fullerton, and C. Don Field, Glendale, are among the coauthors of the "voluntary" plan, fathered by the California Medical Association. Assemblymen Emlay, garageman of Salinas; Ralph C. Dills, school teacher of Compton; Chairman Fred Kraft, San Diego druggist, and Richard McCollister, secretary of the Insurance Brokers' Exchange of San Francisco, gave no evidence of any friendliness toward the compulsory systems during the hearings. Assemblyman Pelletier, Los Angeles, expressed opposition to a compulsory plan. Assemblymen Debs and Evans, both of Los Angeles, and Thompson, San Jose, were counted more likely at this moment to be against than for the compulsory bills.

Senate Feeling

G.O.P. Floor Leader Collins was placed on the committee because of his position. He stated here he authorized the C.M.A. bill at the request of a long-time personal home-town friend.

On the Senate side there is likewise a chilly feeling on the part of many members toward compulsory health insurance.

The controversy is certain to become a battle of experts and statisticians.

From all indications, the C.M.A. group which has employed Clem Whitaker, San Francisco publicist, to handle its drive against the Governor's recommendation and the C.I.O.-A.F.L. and other proponents of compulsory health insurance, do not intend to engage in any cream-puff campaign.

The manner in which cost figures and pro and con arguments are being tossed about by both sides will have the public and the legislators dizzy.

C.M.A. Bill Is An Out

There is a belief among supporters of the Governor's program that the C.M.A. bill, which taps existing State unemployment insurance funds to pay certain medical costs, was dropped into the legislative hopper by the shrewd Assemblyman Collins to give many of the lawmakers an "out."

When the controversy waxes hot, the legislators can say they voted for health insurance by supporting Collins, et al bill, but at the same time can take refuge behind the fact that compulsory health insurance is still in the argumentative stage in California.

C.I.O. leaders have served notice, if no compulsory health measure is passed at this session, they will take the issue to the voters at the 1946 general election. Some skeptics insist that certain of the C.I.O. leaders care not whether the Legislature acts or not, since if it does not they will have an issue for the 1946 campaign.

But Governor Warren's future political fortunes may also be wrapped up in early action on compulsory health insurance.

Many of the Governor's 1942 supporters in industry are against him on this issue. In the Legislature, he seems to have less important support among the Republicans than in Democratic ranks. Yet many Democrats may spike his program so as to deprive him of any credit when the gubernatorial election rolls around two years hence.

Should no compulsory health bill be passed and the C.I.O. proceed with plans to put its measure on the ballot, the Governor then would find himself in the midst of a controversy of great bitterness.

To be consistent he would have to get into the fight which in turn would involve him with many of those from whom he will expect support in his reëlection campaign. This is particularly true in Southern California.—Earl C. Behrens, in San Francisco *Chronicle,* February 19.

ITEM XVI

G.O.P. Studies Health Bill Provisions

Group to Give Report on Insurance Program

Lake Arrowhead, February 19.—(AP.)—The California Republican Assembly today looked to a committee of nine to determine its stand on Statewide health insurance.

Findings of the committee will be reported to directors before the current State legislative session closes.

All resolutions on health insurance plans were tabled by the assembly's directorate in closing a three day conference yesterday. The resolutions committee had reported favorably on voluntary insurance through its chairman, Clarence Rogers of Santa Barbara, but Edgar Hurley of Alameda led a contingent of conferees supporting the program recommended by Governor Earl Warren.

Officers Elected

Arthur Carmichael, San Jose, was elected president, succeeding Murray M. Chotiner, Los Angeles. Other officers include:

Vice-Presidents, John S. Berry, San Bernardino; Bruce Holam, Oakland; Mrs. Edith Heger, Huntington Park; Vroman J. Dorman, San Diego; Clarence Rogers, Santa Barbara; Mrs. Page Monteagle, San Francisco, and Paul Mason, Sacramento.

Glen Baker, San Mateo, secretary; Roy Crocker, South Pasadena, assistant secretary; Harding McGuire, San Francisco, treasurer; Benjamin McNeil, Glendale, assistant treasurer. . . .—San Francisco *Examiner,* February 20.

ITEM XVII

The Warren Health Plan

Governor to Make Public Campaign for His Medical Bill

Governor Warren yesterday announced he would carry his fight for adoption by the Legislature of his compulsory health insurance program directly to the people in a series of radio talks and a limited number of public addresses.

The Governor will make his first radio address over the Blue network, 9 p.m. tomorrow night, he said yesterday.

Because of wartime travel restrictions, the Governor said his public appearance would be made at key cities in the State.

Warren also will discuss various parts of his legislative program in later broadcasts.

The Governor answered a prepared statement issued by the California Medical Association that enactment of a compulsory health insurance act would, in effect, place California medicine in the hands of the politicians.

"Unfortunately," he said, "whenever anyone tries to do something for the public at large, the cry of politics is raised.

"There will be no attempt, so far as I am concerned, to dictate the terms on which we may have health insurance.

"The Legislature can write any safeguards it desires around the system, both to protect the professional standing of doctors and to protect the fund from any kind of mismanagement.

"I believe the Legislature is capable of doing that kind of a job if it gets the coöperation of doctors, employers and employees, all of whom have a right to participate in the program."

The Governor challenged the statements of the opponents of compulsory health insurance that his health insurance plan would require the State to provide $100,000,000 annually to finance it.

"If the people could not afford to have such care under a plan like this, where employers and employees share the costs, then they certainly could not afford to pay for such services through the purchase of voluntary health insurance," he declared.

From Dr. Lowell S. Goin, president, and Dr. Philip K. Gilman, president-elect, came the statement which the Governor answered. The two C.M.A. heads said they would do everything "in our power to keep the hands of politicians from controlling the practice of medicine in California."

They said "a campaign of education will be conducted to awaken people to the menace of political control of medicine, and to encourage and facilitate the extension of voluntary programs for prepaid medical care."

Drs. Goin and Gilman said there will be "no compromise, so far as the California Medical Association is concerned, on the issue of compulsory health insurance."

They said the whole program was "another dangerous step toward regimentation."—San Francisco *Chronicle*, January 20.

ITEM XVIII

Health Program

What goes on at Sacramento is not, as it may at first glance appear to be, a debate which will decide whether there shall be a public health insurance program. If the Social Security administration is any criterion, the present issue is whether we shall have a sound health insurance system established by the people of California for their needs, or wait and get one handed to us by politicians for political purposes.

There was the same kind of pressure for some kind of social security that there is now for public health insurance. The very men and interests best fitted to establish a social security program, if one was to be established, resisted or neglected the opportunity.

The consequence is the present social security administration, in which social security is secondary and politics is the first and more or less constant issue. More talk and brain power is used now to resist the politics than would have provided a sounder program with better security than the present one gives.

The proponents and opponents in the health insurance controversy at Sacramento represent ability that can write a program very much more acceptable to the people of California than a plague of bureaucrats will be.—Editorial in San Francisco *Chronicle*, February 20.

ITEM XIX

Huge Deficit in Health Plan Predicted by State Chamber

Deficits of from $88,000,000 to $204,000,000 a year would be created under any of the compulsory health insurance proposals now before the Legislature, according to a factual report released yesterday by the California State Chamber of Commerce.

Harrison S. Robinson, president of the State chamber, said no policy has been arrived at by the organization concerning the subject of prepaid medical care as a whole, but that a decision will be made later after further study and investigation by committees and the board of directors.

Neither the plans advocated by Governor Earl Warren nor by any other group, could operate without incurring a heavy deficit, the report asserts. It estimates the actual cost per year of the proposed health services as "somewhere between $298,000,000 and $415,000,000."

Other highlights from the State chamber's study include:

1. There is a direct relation between sickness and ability to pay for medical care, with illness increasing as the income level drops.

2. Eighty per cent of California employers provide paid sick leave for their salaried employees.

3. More than 1,500,000 Californians are in various existing voluntary and group programs.

4. California employers now pay about 8 per cent of their total payrolls on workmen's compensation, old age and unemployment insurance. The prepaid medical care plan would add another 1½ per cent, increasing the differential which California employers must surmount in competing with employers in other States.—San Francisco *Examiner*, February 22.

ITEM XX

Warren Takes Health Fight to Taxpayers

He Broadcasts New Appeal for Prepaid Medical Care

Governor Earl Warren carried his fight for compulsory health insurance directly to the people of California last night, urging in a Statewide broadcast from San Francisco that a system of prepaid medical care be set up by the 1945 Legislature, and leaving the door open for compromise on detail.

Warren said he was not surprised at the opposition which the program had aroused, and declared he was comforted by the fact that the opposition "has not, and I believe will not, attempt to argue that the people of our State are receiving or have received adequate medical care.

"All of us," he added, "shudder when we hear stories of what the cost of illness has done to a friend or neighbor. Individually we cannot help them. Collectively we can, and that is what I am proposing."

Urges Full Trial

He added:

"I have no pride of authorship in regard to the details of the bill which I have had submitted to the Legislature. It has been my hope from the outset that the proposal would be thoroughly discussed and debated. No one has all the answers as to how such a program would work in California for it has never been tried here. . . ."

The Governor took no formal notice of the caustic criticism of spokesmen for the California Medical Association in opposing compulsory health insurance. He did, however, reply point by point to the doctors' accusations that he proposed "State medicine."

"Public health has always been considered the responsibility of community and State, and I want to see it remain so," Warren said. "It can only remain so if the State actually accepts the responsibility and solves the problem that confronts us.

Freedom of Choice

"I want to see a program adopted which preserves the existing freedom of choice between patient and doctor.

I do not want to see doctors in the employ of the State. I want to see them paid for their services from a fund that is ample, both to provide the necessary medical care for the patient and reasonable compensation for the doctor.

"I want to see the people pay for what they get and I want to see the control of the program close to the people."

Private health insurance programs now available, Warren said, are not easy to enter, are not universal in application nor all-inclusive in coverage, and "cannot truthfully be said to be adequate for all the people so far as medical care, laboratory tests and hospitalization are concerned."

Doubts System

Of the California Physicians' Service, the Governor commented:

"I believe it is open to serious question whether any program which in six years has attracted the voluntary participation of only 100,000 people out of a population of 8,500,000, will ever be able to fill the public need."

The California Medical Association announced last night through John Hunton, its executive secretary, that it will reply to Governor Warren Friday night, speaking over the same stations. Warren will make his second address next Wednesday night, with the C.M.A. replying again on the following Friday.—(Ed. Note. For reply, see in this issue of California and Western Medicine, on page 108.—R. W. Jimerson, in San Francisco *Examiner*, February 22.

ITEM XXI

Health Insurance

Warren Carries Health Plan Fight to People Over Radio

Governor Warren last night personally carried his proposal for a California program of compulsory health insurance directly to the people.

"In asking the Legislature to create a prepaid health insurance program as a means of improving the general health of our people," the Governor said, "I gave emphasis to my belief that such an effort is a State responsibility."

Warren spoke over the Blue Network in the first of a series of radio addresses in answer to the campaign aimed against his health insurance recommendation to the legislators by the California Medical Association and other organizations.

He declared that the citizens who had been "shocked" at his proposal "were not the millions who so badly need such a system to bring happiness and comfort into their homes." Neither, he said, were they the people "in our State who have pioneered the way in industrial accident compensation, unemployment insurance, aid to the aged and aid to the blind."

On Public Conscience

The Governor said "facts assembled during more than 30 years of study in California are being reanalyzed" and asserted "study and research have begun to cause the problem to weigh upon the public conscience." Time for action has now arrived, the Governor said.

Warren emphasized the fact he did not "want to see doctors in the employ of the State" or did he want to see the present relationship between doctor and patient disturbed.

Warren stressed the need among those in the lower income brackets for the establishment of a prepaid medical care program.

He said the voluntary health programs had failed to reach a sufficiently large number of the population. Warren praised those employers who had set up systems of caring for the health of their workers.

"Out of the millions of people in need of medical care," said the Governor, "there are hundreds of thousands each day of the year who are going about their work only partially capable of doing their job. They cost the employer real money. Proper medical attention could return them speedily to a status of efficiency."

"Individually," Warren declared, "we cannot help them. Collectively, we can, and that is what I am proposing."

Warren said he had "no pride of authorship" in the bill he had submitted to the Legislature, but he believed it was the one "sufficiently flexible in structure so that it can be quickly improved when experience has pointed the way."

He said the bill would not put his plan into full operation until January, 1947, "and even then the inauguration of it can be postponed if the war has not ended."

Coincidental with the Governor's first address, announcement was made that the C.M.A., at the invitation of the Blue network, would also go on the air to present its opposition to Warren's recommendation.

Stanley Cochems, executive secretary, Los Angeles County Medical Association, will make the first broadcast for the doctors, opposing compulsory health insurance, tomorrow night, at 9:45. Dr. Lowell S. Goin, president of C.M.A., will broadcast on March 2.—Earl C. Behrens, in San Francisco *Chronicle*, February 22.

ITEM XXII

Health Insurance to be Forum Subject

A panel of speakers will hold a public forum on "health insurance legislation" at 2:30 p.m., Sunday, in the auditorium of the High School of Commerce, Van Ness Avenue and Hayes Street. The meeting is open to principals, teachers and others interested, and those attending may participate in an open discussion following the panel, Board of Education officials said.

Points of conflict in the pending health insurance legislation will be discussed by Bernard Berkov, member of the professional advisory committee of the Northern California union health committee; Robert Kenny, attorney general of California; Dr. Alson R. Kilgore, member of the California Medical Association, and Dr. Samuel May, of the University of California school of public administration. Professor Max Radin of the University of California will be moderator.—San Francisco *Call-Bulletin*, February 23.

ITEM XXIII

Health Insurance Battle—Round Two

Medical Association Objects to the Cost

The second round in the air lanes battle between Governor Warren and the California Medical Association over the compulsory health insurance issue was fought out last night.

Stanley Cochems, executive secretary of the Los Angeles County Medical Association, speaking for the C.M.A., declared in a Statewide radio broadcast over the Blue network that enactment by the Legislature of a compulsory health insurance act would result in millions of dollars in new taxes and would not improve public health.

Governor Warren opened the radio debate Wednesday night and will return for another round in the fight next Wednesday night over the Blue network.

Cochems predicted that payroll deductions would be insufficient to meet costs of compulsory health insurance, as provided in pending legislation, and that the additional sums necessary to pay hospital and doctors' costs would require doubling the State sales tax, or a State levy on real property, or new taxes on every form of business.

The speaker said both Governor Warren's bill and that sponsored by the C.I.O. have been declared to be "outrageously impractical" by men trained in tax matters.

Cochems estimated that the cost of compulsory health insurance for an estimated 6,500,000 persons would be $250,000,000 a year, based on experience of the California Physicians' Service, which shows $40 per person annually to be the minimum cost of medical care.

He declared that the proposed 3 per cent payroll tax would have raised only $160,000,000 "in the peak year of employment, 1944, leaving an annual deficit of $100,000,000 for the State to pay out of its general fund."

He said the bill for health insurance might run as high as "$520,000,000 a year in California."

Cochems declared that the medical services provided in the compulsory health bills "are not available now and will not be available for years to come."

He said there was a shortage of doctors now and that the doctors could not render additional services.

The speaker declared that compulsory health insurance "would not have changed" the situation relative to draft rejections. He declared England with compulsory health insurance for 30 years had a much higher percentage of rejections for physical and mental reasons, than the United States.

"Study of prepaid health insurance in practice, not theorizing, is needed before plunging California into a morass of debt," said the speaker. He contended the "3,000 California doctors in military service" should have a voice in the final decision on health insurance, which he declared was not a matter of urgency "at this time." —Earl C. Behrens, in San Francisco *Chronicle*, February 24.

ITEM XXIV

Pros, Cons of Health Plan Told at Forum

Pros and cons of health insurance, compulsory vs. voluntary, were discussed yesterday afternoon in an open forum at the auditorium of the High School of Commerce.

Dr. Alson R. Kilgore, speaking for the California Medical Association's voluntary health proposal was opposed by three principal and several secondary speakers who urged adoption by the Legislature of a compulsory health insurance act.

Professor Samuel May, University of California School of Public Administration, reviewed the history of the 30 years of study of the health insurance subject in California.

Costs Too High

He declared surveys had shown that one-third of the people in the United States were unable to maintain medical and hospital services for themselves because of the costs.

"Nowhere," said Professor May, "has the voluntary plan even scratched the surface." He said the California Physicians' Service, a voluntary plan, had only been able to reach something over 100,000 people out of the 8,000,000 in California. He urged approval of a compulsory health bill.

Dr. Kilgore said the C.M.A. recognized the need for adoption of a plan for a better distribution of the costs of medical care, but "we object to seeing the care of the sick placed under political control." He declared the C.M.A. voluntary bill proposed that workers be permitted to use a part of their future unemployment payments for sick benefits.

Dr. Kilgore urged that no action be taken upon compulsory health insurance "until the 3,000 doctors in the service and the 800,000 Californians in the armed forces return home and have an opportunity to express themselves."

Tax Insufficient

He said the programs as provided in both Governor Warren's bill and that sponsored by the C.I.O. would cost more than the amount which the 3 per cent pay roll tax would raise.

Dr. Kilgore said there was $630,000,000 in the State's unemployment fund. "We propose," he declared, "no tapping of that fund, but we propose that in the future a part of the employees' tax be remitted.

Attorney General Kenny, who advocated compulsory health insurance and payment of doctors by the capitation, or set sum per person per year plan, analyzed the four principal health insurance measures now pending before the Legislature. These included Governor Warren's, the C.I.O. measure, the California Farm Bureau proposals and the C.M.A., or "doctors' bill."

Kenny expressed the belief that the doctors' bill "would deplete the State's unemployment fund." . . .—Earl C. Behrens, in San Francisco *Chronicle*, February 26.

ITEM XXV

State Must Control

Illustrative of the progress in public thinking made by the idea of public health insurance is a recent statement of the social security committee of the Life Insurance Association of America. It says government experiments with public health insurance should begin at the local or State levels, not at the Federal level.

Time was, and not too distantly in the past either, that life insurance authorities were intolerant of public health insurance on any level. They were just against it *per se*. This indication that they would be willing now to have it tried experimentally on local and State levels is a decided liberalization of attitude.

With the committee's conclusion we decidedly agree. We believe the machinery of administration of whatever plan is adopted should be under State management instead of under national bureaucratic control too remote from the beneficiaries to be easily modified in case of need. An important requirement is that the plan be flexible enough, at least in the experimental stages, to permit of changes the moment any details prove unworkable.

That does not kiss the Federal Government out of the picture entirely. It may be some measure of its participation may be worked out similar to the unemployment insurance arrangement. But still, the control and operation should be in State hands.—San Francisco *News*, February 26.

ITEM XXVI

Health Program

Voluntary Insurance Plan is Urged by Farm Bureau Representative

Establishment of voluntary rather than compulsory health insurance program in California was urged yesterday in a Hotel St. Francis luncheon talk by Von T. Ellsworth, representative of the California Farm Bureau Federation.

Ellsworth opposed both the proposals of Governor Warren and the C.I.O.'s, and other compulsory health insurance bills now pending before the Legislature.

Addressing a group which included doctors, dentists, and representatives of business and industry, Ellsworth asked support for two measures introduced in the Legislature by Senators George J. Hatfield, Merced County; Bradford S. Crittenden, San Joaquin County, and Louis G. Sutton, Colusa County. The Farm Bureau Federation is sponsoring the bills.

Ellsworth said there seemed to be general agreement that health facilities and services are inadequate and that they are unevenly divided. Furthermore, he said, the ruinous aspect of unexpected large doctor and hos-

pital bills can be avoided through health insurance methods.

Health Association

One of the bills sponsored by the Farm Bureau group would encourage the formation of associations of doctors or of laymen to make health service available to those who want to buy it.

The second of the measures would make tax-supported county hospitals available on a cost and ability to pay basis for those who choose to use them, those who have peculiar diseases which can best be treated there and to those who cannot afford the private health service under the voluntary association plan.

Although admitting that until present statutes are changed the proposed compulsory health insurance coverage would not apply to the farmers, since neither they nor their laborers are subject to unemployment insurance, Ellsworth objected to the compulsory plan on the ground it was regimentation.

Senate bill No. 218, first of the Farm Bureau Federation bills, declares the purpose of the act is "to empower county boards of Supervisors to authorize the use of a county hospital by all the residents of the county and to charge the costs so incurred to each individual using such facilities in accordance with his ability to pay such costs."

Ellsworth said adoption of this proposal "will necessitate the construction of some Government hospitals."

The other bill would require all health associations to be licensed by the State Department of Public Health, which is its administrative body. It would direct the department to issue a license upon the approval of a contract, if it is convinced the provisions of the contract can be fulfilled, and upon receipt of $25 as a filing fee. The State Health Department would require necessary medical reports and the performance of a high standard of medical service. The act also provides for the incorporation of doctors or laymen to provide health service.

Ellsworth contended the voluntary program of his organization would provide "the long-needed law legalizing periodic payment plans which will encourage doctors to engage in this form of practice."—Earl C. Behrens in San Francisco *Chronicle*, February 9.

ITEM XXVII

Northern G.O.P. Refuses Okeh of Health Bill

Section of State Central Committee Declines Also

Republicans of the State Central Committee, Northern section, late yesterday tabled a proposal to indorse the broad principles of Governor Warren's legislative program and rejected every effort to array a policy or take a stand on state affairs. . . .

Chester MacPhee, San Francisco supervisor, made a strong plea for some overall indorsement of Governor Warren's program, as a liberal and farsighted approach his party should support. He acknowledged he is not in sympathy with every Warren idea (especially taxes) but said the direction is right.

"We ought to try to raise standards of the Republican Party to the level of the plain working man," he declared. "Until we gain confidence from plain Mr. Jones, we Republicans won't gain votes."

In lively discussion that followed, the motion was tabled and Governor Warren cold-shouldered. . . .—San Francisco *News*, February 28.

ITEM XXVIII

Forum Favors Compulsory, Not Voluntary Health Plan

A poll taken at last Sunday's, February 25th, public forum on health insurance showed 84.2 per cent of the 272 persons who voted favored the compulsory system, as against 14.3 per cent who favored voluntary insurance, with 1.5 per cent of those voting opposed to any system. The forum was held at the High School of Commerce of San Francisco. The poll was taken by the Northern California Union Health Committee which sponsored the forum in conjunction with other groups.

On the question of payments for operation of a health system, 264 persons in attendance at the meeting voted. Of this number, 82.5 per cent favored an equal employee-employer payroll deduction; 5.3 per cent voted for deductions by employees only and 9.4 per cent were opposed to any employee deductions.

Control of the administration of a health insurance act by a public body with professional advice was favored by 90.6 per cent, while 9.4 per cent wanted the administration to be in the hands of the medical professional only. The capitation, or set sum per person per year, plan of paying doctors was favored by 78.7 per cent, as against 21.2 per cent who voted for the fee-for-service, or fee for each service rendered.—San Francisco *Chronicle*, March 1.

ITEM XXIX

Nurses Association Ask Health Plan

The California State Nurses Association wants nursing included in any State health insurance program and will seek a hearing before meetings of the Assembly public health committee in San Francisco on March 2, Miss Shirley C. Titus, executive director of the organization, announced yesterday.

"We believe that nursing services should be provided for under any health insurance plan when these services are deemed necessary by the physician in charge," Miss Titus said. "We are prepared to offer an amendment to any health insurance bill coming before the Legislature, making provisions to this effect."

The nursing profession should also have a place on the board of the proposed Health Service Authority, or on the executive body of any other approved system, Miss Titus added.—San Francisco *Examiner*, March 1.

ITEM XXX

Legislators Clash at Fresno Health Insurance Hearing

Fresno, Feb. 28.—(AP.)—Controversy over the 13 different health insurance bills now before the State Legislature flared into a row here today between various members of the Assembly's Interim Committee on public health over a purported analysis of the principal measures being read before a public hearing by Chairman Fred Kraft of San Diego.

Assemblymen Edward Gaffney, San Francisco, co-author of Governor Warren's original bill, and Jack Massion, Los Angeles, author of another of the bills, interrupted Kraft's reading with charges the analysis gave the Fresno audience a wrong and biased impression of the content and effect of some of the measures.

"Are you reading an argument against the bills or an analysis?" Gaffney demanded. "You are building up the California Medical Association plan and tearing down the Governor's bill."

Kraft replied he was reading an analysis of the principal bills at the request of numerous people in the audience and the analysis, which was prepared by the Medical Association, was the best material at hand.

"Because the State Chamber of Commerce said so," Gaffney interjected.

Vice Chairman Ernest Debs of Los Angeles demanded order and requested Gaffney and Massion to allow Kraft to continue.

Gaffney's original interruption was made after Kraft read from the Medical group's analysis that the 3 per cent pay roll tax proposed by Warren would fall short by more than $100,000,000 of paying the cost of the program.—San Francisco *Chronicle*, March 1.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Legislative Bulletin

The Public Health League of California

Hotel Sacramento

Sacramento, California

The Legislature recessed late Saturday night, January 27th, after a 19-day session which saw 3,358 bills introduced. The sessions were resumed on March 5th.

During the closing hours of Saturday hundreds of bills were poured into the hopper and it is impossible to know at this time just what all of them contain. War time conditions in the State printing office have slowed down production, so that, at this writing, only about one-half of the bills are in print.

Health Insurance

Health Insurance has been the Number One topic of discussion in Sacramento. Many newspaper writers predict that it will spotlight the present session. In his message to the opening session of the Legislature, Governor Warren urged enactment of a Health Insurance Plan. This was implemented with the introduction of bills in the Assembly and Senate, prepared at his suggestion.

Other bills have also made their appearance and, to date, we have found 14 that touch upon this subject or are closely related to it.

These are:

Senate Bill 218 (By Hatfield, Crittenden and Sutton) relating to admission to county hospitals and medical care at county expense.

Senate Bill 219 (By Hatfield and Sutton) authorizing and governing the practice of group medicine.

Assembly Bills 1110 and 1111 (By Stephenson and Lowery) companion bills to the above.

Senate Bill 500 (By Salsman, Shelley and Dillinger) Governor Warren's Compulsory Health Insurance Plan.

Senate Bill 699 (By Carter) relating to County Hospitals and admission of pay patients thereto.

*Assembly Bill 449 (By Thomas, Dekker, Anderson, Massion, Fletcher, Hawkins, Kilpatrick and Rosenthal.) (This is the CIO bill for Compulsory Health Insurance.)

*Assembly Bill 800 (By Wollenberg, Fourt, J. C. Lyons, Doyle, Brown, Dunn, Fletcher, Gaffney and Waters). (This is Governor Warren's Compulsory Health Insurance Bill.)

*Assembly Bill 1200 (By Sam L. Collins, Field, Werdel, Erwin, Knight, Stewart, Stream and Watson.) (This is the CMA bill for the encouragement of voluntary medical, surgical and hospital plans.)

Assembly Bill 1414 (By Rosenthal) Duplicate of the Olson bill of 1939.

Assembly Bill 1525 (By Massion and Dunn) providing for a comprehensive health service to the people of California.

Assembly Bills 1595 and 1596 (By Wollenberg, J. C. Lyons and Fourt) making the necessary appropriation for Governor Warren's Health Insurance Plan

Digests of all of the above bills are now being made and should be available at an early date.

The Assembly Bills relating to Health Insurance have been referred to the Committee on Public Health, which comprises the following members:

Assembly Committee on Public Health

Chairman—Fred H. Kraft, Pharmacist, P. O. Box "C," Ocean Beach Sta., San Diego.

Vice-Chairman—Ernest E. Debs, Tax Statistician, 1633 Lyman Place, Los Angeles.

Sam L. Collins, Attorney, N. Cypress Ave., Fullerton.

Ralph C. Dills, Teacher, 1505 N. Spring St., Compton.

Fred Emlay, Manager, 812 Pajaro St., Salinas.

John W. Evans, Accountant, 3745 S. Grand Ave., Los Angeles.

C. Don Field, Trucking Contractor, 1552 Ridgeway Dr., Glendale.

Edward M. Gaffney, Insurance, 295 Sanchez St., San Francisco.

Augustus F. Hawkins, Business, 220 E. 46th St., Los Angeles.

Jack Massion, Druggist, 846 E. 77th St., Los Angeles.

Richard H. McCollister, Insurance Broker, 321 Sycamore Ave., Mill Valley.

John B. Pelletier, Research, 248 S. Olive St., Los Angeles.

John F. Thompson, Farmer, Rt. 3, Box 408, San Jose.

(During the Legislative Session the address of each of the above is State Capitol, Assembly Chamber, Sacramento.)

Senate Committee on Government Efficiency

The Senate Bills relating to this subject have been referred to the Committee on Governmental Efficiency, which comprises the following members:

Chairman—Ralph E. Swing, Attorney, 313 Central Building, San Bernardino.

Vice-Chairman—Harold J. Powers, Rancher, Eagleville.

Hugh M. Burns, Funeral Director, 2055 San Joaquin, Fresno.

Randolph Collier, Title Business, Yreka.

T. H. DeLap, Attorney, American Trust Building, Richmond.

George J. Hatfield, Farmer, P. O. Box C, Newman.

Thomas F. Keating, Attorney, Freitas Building, San Rafael.

Thomas McCormack, Rancher, Rio Vista

Harry L. Parkman, Wholesale and Jobber, 8 Corte Dorado, Millbrae.

W. P. Rich, Attorney, Marysville.

Jerrold L. Seawell, Insurance, 308 Mariposa Ave., Roseville.

(During the Legislative Session the address of each of the above is Senate Chamber, State Capitol, Sacramento.)

The C.M.A. is definitely opposing Assembly Bills 449 and 800, and solidly favoring Assembly Bill 1200. (Bills starred in the list.)

Medicine

The State Board of Medical Examiners has introduced no bills in the present session of the Legislature.

In addition to Assembly Bill 1200 (mentioned above), the CMA has sponsored a bill empowering the Industrial Accident Commission to adopt rules and regulations governing medical and surgical service and a schedule fixing the reasonable value of such services rendered to employees. Assemblyman King of Oroville is the author of this bill.

Dentistry

Organized Dentistry has sponsored two bills—

Assembly Bill 1597 (By Wollenberg and Kraft) mak-

ing an appropriation to the State Department of Public Health for establishment of a Division of Dental Health.

Assembly Bill 1598 (By Wollenberg and Kraft) relating to Division of Dental Health in the Department of Public Health.

Shift in Security Strategy

The Wagner-Murray-Dingell bills now pending in Congress, which would provide everything in social security "including the kitchen sink," will be split into four or five separate proposals replacing the omnibus measure, according to American Federation of Labor spokesmen who recently wound up their annual convention in New Orleans.

The AFL has been carrying the ball in this field of social legislation, with support from the rival CIO.

Under the projected plan, which is yet to be cleared with the congressmen who have the last say, extension of old age and survivors' insurance to "the missing 20 million" would be put up to Congress in a bill distinct from others dealing with such controversial questions in as so-called "socialized medicine" and federalization of state employment insurance systems.

The AFL men have noted that the complete Wagner-Murray-Dingell bills have been resting in congressional committees for a year and a half, without even hearings. They appear to realize the truth of what congressional observers have been telling them—that it would be easier to get favorable action on the popular parts of the propositions by divorcing them from the proposals which aroused strong group opposition.

Foremost in the popular class is the proposal to give social security cards to the 20 million workers who were left out by Congress in the original law. They include agricultural workers, the self-employed, and employees of state and local governments not now covered by public pension plans.

COMMITTEE ON SCIENTIFIC WORK

Subject: 1945 Annual Session
Memorandum—February 16, 1945

The requirements of the Federal Office of Defense Transportation are as follows:

(1) Any convention or meeting *must be less than 50 persons* who would require public transportation, etc., in order to accomplish three things:

1. Avoid the use of public transportation, such as railroads.
2. Prevent crowding hotels with overnight guests.
3. Prevent throwing extra manpower work upon hotel managements, through extra care of meeting rooms.

In order to accomplish the above ends, the California Medical Association which hopes to hold its 74th Annual Session in Los Angeles on Sunday-Monday, May 6-7, 1945, is proceeding as follows:

I. The only official delegates from Northern California, for whom the California Medical Association will be responsible, will be General Officers and Delegates of component county societies, not to exceed the number of 46.

II. Meetings of the California Medical Association will be held, not in hotels, but in the Elks Temple and the headquarters of the Los Angeles County Medical Association, thus avoiding hotel service.

III. The Scientific programs will be carried through, but with Los Angeles members in charge of the meetings.

In addition, C.M.A. members who are not resident in Los Angeles, will be permitted to have their papers read "by title," thus allowing the articles to be eligible for publication in the Official Journal, CALIFORNIA AND WESTERN MEDICINE.

Or, such non-Los Angeles resident C.M.A. member may ask some Los Angeles member to read his paper, through mutual arrangement that may be satisfactory to the Section Officers.

IV. C.M.A. members who may be on the programs of the Scientific Sections and who do not live in the City of Los Angeles, will be requested to motor into Los Angeles for Sunday morning or afternoon, or Monday morning or afternoon, in order to avoid the use of public transportation.

V. C.M.A. Committee on Scientific Work hopes to secure military colleagues stationed in hospital stations of Army camps near Los Angeles to present papers. Such military colleagues can motor back to their stations on same day, thus avoiding overnight accommodations in hotels. (See also comment on page 106.)

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

U. S. Losses 536,950*

Army Figure 461,058; Navy 75,892

Casualties for the armed forces have reached 536,950. From Pearl Harbor through November 15. Army casualties amounted to 461,058, Secretary of War Stimson said on November 30.

This was an increase of 6,878 in one week from November 7.

Navy casualties are 75,892, an increase of 1,277 for the week.

Here are the Army casualties, together with those a week ago: Killed, 89,840 and 88,245; wounded 258,106 and 254,283; missing 57,514 and 56,442; prisoners 55,598 and 55,210.

The Navy casualties: Killed 29,480 and 29,208; wounded 32,600 and 31,574; missing 9,326 and 9,347; prisoners 4,486 and 4,486 (unchanged).

The War Department made public these Army casualties for each theater from the start of the war through the end of October.

Killed	*Missing*	*Wounded*	*Prisoners*	*Total*
		ASIATIC		
1,122	921	1,603	159	3,805
		CENTRAL PACIFIC		
2,344	622	5,273	10	8,249
		EUROPEAN		
45,316	28,500	136,642	25,277	235,735
		MIDDLE EAST		
823	1,886	639	1,693	5,041
		NORTH AFRICA		
25,876	5,564	79,216	13,376	124,032
		NORTH AMERICAN		
1,305	52	1,052	...	2,409
		*PHILIPPINES		
1,101	14,933	1,690	12,892	30,616
		SOUTH PACIFIC		
2,504	504	7,278	8	10,294
		SOUTHWEST PACIFIC		
4,420	2,029	9,661	1,065	17,175
		GRAND TOTAL		
84,811	55,011	243,054	54,480	437,356

* Does not include casualties from the present Philippine campaign.

Production, Casualties Totals Cited By British White Paper

The colossal measure of Britain's war effort was re-

* Owing to lack of space, this item was crowded out of previous issues. U. S. casualties on February 2, 1945, reached total of 737,342. See February CALIFORNIA AND WESTERN MEDICINE, on page 96.)

vealed in London for the first time on Novembre 28 in a Government white paper showing the British Isles alone produced 102,000 planes and 25,000 tanks and suffered almost 700,000 civilian and military casualties in the first five years of World War II.

The official report showed Britain's war spending has reached the astronomical height of $634 a second, and the proportion of her population mobilized for war is perhaps greater than that of any other belligerent power.

Other statistics, revealed now because the war has progressed to the point where absolute secrecy is no longer essential, included:

1. Britain's armed forces now number 4,500,000 men and 500,000 women out of a total population of about 47 million.

2. More than one-third of all men in the United Kingdom between the ages of 14 and 64 are under arms, and almost half the women between 14 and 59 are in the armed forces, full-time civil defense or industry.

3. By the close of 1943 Britain had lost 11,500,000 tons of shipping, two-thirds of the tonnage with which she entered the war.

4. Casualties in the armed forces of Great Britain alone numbered 563,000 by the end of last September, including 176,000 killed; for the rest of the Empire, casualties totaled 363,000, including 67,000 killed.

5. One out of every three houses in Britain has been destroyed or damaged in air raids or by robot bombs, and civilian casualties up to the end of August numbered 57,298 killed and 78,818 injured.

6. Another 29,629 British merchant seamen were killed by enemy action and 4,173 interned by the enemy since the start of the war. . . .

More Military Hospitals

Army will soon be ready with extensive program of convalescent hospitals for wounded overseas veterans. Main objective is to provide accommodations for thousands of long-time convalescents who are able to walk and exercise.

Anticipating a steady increase in casualties from overseas, Army is trying to provide a maximum of bed space in its general hospitals which are equipped for most advanced types of medical and surgical attention. It's already beginning to move out of its general hospitals men who are able to be around, who do not need constant medical or surgical attention.

Question: Will Army and Navy continue to operate all the hospitals built for them, after the war? Or will they be turned over to the Veterans' Administration? And, as the number of hospitalized men decreases, which hospitals will be turned back to civilian uses and which will the Government keep?—"Washington Calling" in San Francisco *News*, December 2.

U. S. Prisoners

The House Military Committee reported recently that American prisoners of Germany are, in the main, humanely treated.

It said prisoners in Japan proper seem to be faring better than those in Japanese-occupied territories.

And Axis prisoners in the United States, it said, are well treated but not pampered. . . .

At the time the investigation was completed, in December, the committee said, there were 281,344 German, 51,032 Italian and 2,242 Japanese war prisoners in 132 base camps and 334 branch camps. . . .

"On the whole," the report said, the camps in Japan, China and Manchuria, in which an estimated 6,296 Americans are held, "seem to be more humanely administered" than those in distant Japanese-occupied territories in which there are approximately 9,865 Americans.

The committee said Swiss representatives confirmed reports that the food given prisoners in Japanese camps is superior to that available to Japanese civilians.—San Francisco *Chronicle*.

Medical Department Trains Medical Administrative Corps Officers as Battalion Surgeon Assistants

In order to relieve the critical shortage of doctors, the Medical Department has recently increased its quota for admission to officer candidate schools and has initiated a new program of training graduate administrative officers as battalion surgeon assistants. Between now and April, 1945, appointments will be made in the Medical Administrative Corps after seventeen weeks training at Camp Barkeley, Texas and Carlisle Barracks, Pennsylvania.

From among these graduates, officers with appropriate backgrounds will be selected to receive six weeks additional training at Camp Barkeley for duty assisting battalion surgeons. The special training consists principally of advanced first aid which will qualify these officers to relieve battalion surgeons of details and thus permit the surgeons' time for purely medical and surgical work.

Redbook Edition of "The Army Nurse" Available

The history of military nursing is told in an illustrated 32-page special "Redbook" edition of *The Army Nurse*, just off the press. Starting with the unrecorded past, the story of nursing is traced from earliest traditions to the birth of military nursing, and through the history of American military nursing to the work of the present U. S. Army Nurse Corps. Illustrations range from reproductions of old art to photographs from Civil War times on. The "Redbook" edition, which has been published as an aid in the procurement program of Army nurses, is available to anyone who requests it from the Nursing Branch, Technical Information Division, Office of The Surgeon General, 1818 H Street N. W., Washington 25, D. C.

C.M.A. CANCER COMMISSION

Health Maintenance and Cancer Prevention Clinics*

Cancer Detection or Prevention Clinics are growing so rapidly that a review of their brief history is timely.

The first clinic was started at the Woman's Medical College of Pa. in 1937. Its purpose was to make pelvic and breast examination on 1,000 women semi-annually for five years. Correction of chronic local irritation was advised. If after five years a decrease in the incidence of cancer in these organs, or the favorable prognosis because of early diagnosis and treatment of cancer was noted, expansion of these clinics was indicated. In 1944, 1,317 patients had been seen. Eleven cancers diagnosed, ten without symptoms, one carcinoma of the breast developed four months after the last examination, which was negative, and had axillary metastases when promptly operated on. All cancer patients are well in 1944, two to five years after diagnosis. About five cancer

* This contribution is one of several articles which will appear in CALIFORNIA AND WESTERN MEDICINE, under the sponsorship of the Cancer Commission of the California Medical Association with the hope that they will elicit greater interest in the problems of cancer and in coördinated efforts at their solution.—Isabella H. Perry, M.D.

deaths would have been expected from this age group. Four hundred forty-two pre-cancerous conditions were found. On the whole, coöperation in following corrective advice was good. In 1937 the New York Infirmary for Women and Children set up a Cancer Prevention Clinic for women. This clinic gave a complete physical examination. Special examinations were ordered at the discretion of the examining physician. This clinic was so successful that in 1940 a similar clinic was opened at the Memorial Hospital in New York. In 1944 the two clinics had examined 1,800 patients, finding 7.9 per cent with cancer. *The majority of the cases were early.* Four cancers and 50 benign tumors were found in 263 patients without symptoms.

On the basis of the results obtained in these pioneer clinics, the American Cancer Society, the International Cancer Research Foundation and the Veterans Administration are now supporting the establishment of such clinics. It is desirable that the above stated organizations agree on minimum standards for clarity and unity of purpose, and to avoid overlapping of effort.

The first clinics were in recognized hospitals, staffed by doctors experienced in cancer diagnosis. Thoroughness in examination and continued reëxamination were cardinal principles. The prevention clinic was supplemental to the Cancer Diagnostic and Treatment Clinic of the hospital. The clinics now being established in general hospitals, take both men and women. Attendance has exceeded expectation wherever clinics have been opened.

Space does not permit detailed recounting of operational and recording methods of the clinics. Health Maintenance is an important part of this work. Many more cases were referred to private physicians than were sent in by them. The clinics and recording and follow-up are maintained in conjunction with the private physicians. A flat examination charge is reassuring to the prospective patient who may be anxious about unspecified or cumulative charges. Until the clinic registrations are larger and acturial experience accumulates, a clinic should have a reserve fund for the more expensive examinations. The patients must have emphasized that there is no guarantee of cancer prevention. That inaccessible tumors remain very difficult to diagnose early, that periodic examinations are essential, and that one must return and report an untoward symptom when it occurs, and follow recommended treatment. It is deemed inadvisable to set up a clinic unless it will operate for at least five consecutive years.

For years the insidious and painless onset of cancer has been known, but no one organized and made provision that examinations should be made prior to the time when the patient complained of symptoms.

Eighty-five per cent of skin cancer, 90 per cent of lip cancer, 80 per cent of uterine cancer, and 75 per cent of breast cancer can be cured when diagnosed early, and promptly and adequately treated. To take these statistical estimates off paper, and make them clinical realities is the purpose of the cancer prevention clinics. A purpose sanctioned by intelligent humanitarianism.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

The Los Angeles County Physicians' Aid Association

For the Relief and Care of Worthy, Needy Physicians

Sponsored by the Los Angeles County Medical Association.

Whole-heartedly supported by an increasing number of members of the Profession.

Subscriptions are Income Tax exempt.

* * *

What Is the Los Angeles County Physicians' Aid Association?

The Los Angeles County Physicians' Aid Association is a nonprofit corporation operating under the laws of the State of California.

Its officers and members of its Board of Trustees are members of the Los Angeles County Medical Association. Its books and records are open to the Board of Trustees of the Los Angeles County Medical Association for inspection and suggestions at all times. No activity of any moment is engaged in by the Los Angeles County Physicians' Aid Association without the approval of the Board of Trustees of the Los Angeles County Medical Association.

Members of the Committee on Relief and Fraternal Relations of the Los Angeles County Medical Association take a most active part in the management of the Los Angeles County Physicians' Aid Association.

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Kenneth C. Brandenburg, M.D. *Vice-President*
Orrie E. Ghrist, M.D. *Vice-President*
Harold E. Crowe, M.D. *Asst. Vice-President*
Paul D. Foster, M.D. *Secretary-Treasurer*

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E. Vincent Askey, M.D.	Frederick G. Gruber, M.D.
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Max W. Bay, M.D.	Wayland A. Morrison, M.D.
Philip J. Cunnane, M.D.	A. J. Scholl, M.D.

Legal Counsel

Louis J. Regan, M.D. William W. Vaughn

* * *

I WILL GIVE

.....

CASH CHECK PLEDGE

(Tax Exempt)
To
LOS ANGELES COUNTY PHYSICIANS' AID ASSOCIATION
1925 Wilshire Boulevard
Los Angeles 5, California

For the purpose of helping needy doctors or their fam-

ilies who through no fault of their own find themselves in distress.

This money will be placed in the fund OF PHYSICIANS, FOR PHYSICIANS, BY PHYSICIANS.

Signed.....

* * *

Excerpts from a Letter:

Los Angeles County Physicians' Aid Association
Los Angeles County Medical Building
1925 Wilshire Boulevard
Los Angeles 5, California
Founded 1937
October 4, 1944

Dear Doctor Kress:

We are indeed pleased by your interest in us, particularly referring now to the project of the Los Angeles County Physicians' Aid Association.

Our campaign to raise $500,000.00 is now actively under way. The score at this moment is $81,346.00. This is being carried on as a "family affair" without recourse to professional agencies.

Sixty-nine of the busiest practitioners in Los Angeles County have accepted assignments as local chairmen in the various areas, hospitals, and buildings in the County. They are functioning with enthusiasm and determination. Admittedly we are all amateurs in this sort of thing and are striving to learn as we go along.

I am enclosing a rather miscellaneous group of some of the material we have used or are using. We have rather definitely concluded that personal individual contact with each prospect is essential to obtaining best results.

We will keep you informed of our progress.

Sincerely yours,
For the *House Fund Committee,*
(Signed) Louis J. Regan, M.D.

* * *

Excerpts from Recent Editorial in "The Bulletin" of the Los Angeles County Medical Association:

A Rare Privilege

This issue of the *Bulletin* goes to press just as the campaign of the Los Angeles County Physicians' Aid Association to reach its goal of $500,000 is swinging into high gear. Enthusiastic volunteers are serving as campaign chairmen, each being assigned to an office building, hospital, or district. Every member of the Association will be given the privilege of making his or her contribution to the fund. Precampaign subscriptions total almost $70,000. This includes twenty or more gifts of $1,000.00 and several of $500.00 or more—striking evidence of the hearty and sincere approval with which the program is regarded.

We all participate in drives to raise money for charity, campaign funds, and other purposes. . . .

No person, however comfortable and apparently secure his circumstances may be, can have any assurance that his health and his financial assets will not be swept away. . . . The present Federal social security program does not include professional workers who are self-employed—we must provide for ourselves. We can do a good job of this without red tape and bureaucracy—two things involved in most governmental projects.

Eligibility for care and assistance from this fund will be determined by rules established by the board of directors of the Physicians' Aid Association with the approval of the board of trustees of the County Medical Association. All members and former members of the Los Angeles County Medical Association will receive preference. Assistance will be given to other deserving physicians and their families whenever facilities and funds permit. No member will be denied care because of failure to contribute to this fund. . . .

Our county medical association has an enviable record of accomplishment. The library, the permanent quarters building, the scientific programs, the innumerable services to members—all of these are fine and laudable. In this present undertaking we are making it very certain that our own medical brethren and their loved ones will never face the spectres of privation and want. The eagerness and enthusiasm with which our members are rushing this program to successful completion is indeed inspiring. Forty-two individuals are receiving aid from the Association at the present time. At the height of the depression more than eighty were being helped. More than half of the beneficiaries have been widows of physicians.

The officers and directors of the Physicians' Aid Association are hopeful that someone will make a gift of a suitable tract of land, perhaps twenty, or thirty acres, as a site for the home. To quote Dr. Louis J. Regan, who is serving as organization chairman, "No one associated with the project is entertaining any fantastic ideas as to the home. Rather, it is contemplated that modest units will be built as they are needed or that war industry units may be purchased and moved onto the property. Further, it is realized that help may be rendered more economically in some instances by aiding in the maintenance of a physician or his family somewhere other than at the home."

The committee in charge of the campaign hopes to reach its objective within two months. To join in this project is a rare privilege and in no sense a burden. Many of our colleagues are giving everything they have on the battlefields. Let us all seize the opportunity to add to the security and safety which they will have upon their return, and to that of their wives and children if they never return.—E.T.R.

(Note. See also California and Western Medicine, for July, 1944, on page 36.)

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Southern Pacific Hospital

A vice president of the Southern Pacific who started work for the company as a laborer 25 years ago declared, on February 7, that there is no need for turning control of the railroad hospital over to labor representatives.

D. J. Russell, vice president in charge of the company's hospital department, was testifying before the arbitration board which is conducting a hearing at the Appraisers' building on a dispute between 15 railway labor organizations and the railroad about the Southern Pacific general hospital in San Francisco.

Russell, after telling of his work as laborer, track foreman, and in an ascending succession of other posts for the company, said that as a patient at the hospital when he held lower positions he had always been satisfied. He added that now he never goes to any other hospital as he considers the railroad one outstandingly good.

The railroad vice president said the hospital department is not operated for profit, and that when expenditures exceed receipts the company advances funds to make up the difference.

The witness said that the scale of company cash contributions to the hospital at present is $70,000 a year, and that it also defrays cost of maintenance of various

emergency hospitals, and furnishes free transportation to hospital department employees and patients.

Burton Mason and Henley Booth, attorneys for the railroad, engaged in several clashes with H. P. Melnikow, representing the labor organizations, when Melnikow cross-examined Russell.

"Did you ever belong to any of the railway labor organizations involved in this dispute?" was one of the questions Melnikow asked.

The witness replied that he had not.

At another point, cross-examining Russell on his stand that no change in the managing methods at the hospital is needed, Melnikow asked:

"In other words, you know what's best for the employees—is that your attitude?"

The labor organizations claim that they put up more than 90 per cent of the hospital fund through deductions from wages, and are asking for majority representation on a board of hospital management.

Chief Justice Leif Erickson of Montana heads the arbitration board.

City Loses in Hospital Case

Court Rules Patient Not Liable for Expense

Municipal Judge Daniel R. Shoemaker, of San Francisco, on February 7, handed down an opinion to the effect that persons receiving hospitalization in San Francisco public hospitals are not liable for the cost thereof unless an investigation is made by proper authorities as to their ability to pay.

The decision was rendered in the case of the city against a Mrs. William Perry, who was treated at San Francisco Hospital, and subsequently billed for services. The court rendered a verdict in favor of Mrs. Perry, including her costs in the action.

"No evidence was offered of any action by the board of supervisors, as required by the Welfare and Institutions Code, as to whether any investigation was made, or finding, or determination as to the pecuniary ability of defendant to pay, or her other family responsibilities."

Observers said the decision was important because it may affect various other suits the city has pending for recovery of hospitalization.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (90)

Alameda County (1)

Bechtol, Charles O., *Oakland*

Butte-Glenn County (1)

Calahan, L. J., *Chico*

Kern County (2)

Bernard, Marion, *Bakersfield*
Cutting, George H., *Delano*

Los Angeles County (70)

Adashek, Eugene Phillip, *Los Angeles*
Amsel, Maxwell Ritter, *Los Angeles*
Anderson, Harold Edward, *Long Beach*
Barrows, Charles Viole, *Santa Monica*
Bower, Daniel L., *San Marino*
Brodwin, Allen L., *Los Angeles*
Burbach, Theodore H., *Beverly Hills*
Carver, Cyril Ellis, *Pasadena*
Caster, John Leslie, *Los Angeles*
Cook, Jesse D., *Huntington Park*
Crosiar, Donald M., *Hawthorne*
Cruice, Leman D., *Alhambra*
Crumrine, Martin H., *Los Angeles*
Currier, Wilbur Dale, *Pasadena*
de Dworzak, Zdenko V., *Santa Monica*
Denmain, Herman H., *Los Angeles*
Dollinger, Alethea M., *San Gabriel*
Eisenbeiss, John A., *Los Angeles*
Failing, Joseph Henry, *Los Angeles*
Fantl, Kurt, *Duarte*
Field, John Weslie, *Burbank*
Fisher, Louis J., *Glendale*
Flynn, John F., *Santa Monica*
Gilrane, John J., *Fort Lyon, Colorado*
Gotfredson, Elmer J., *Alhambra*
Gray, Arthur S., *Long Beach*
Gregorius, H. Harvey, *North Hollywood*
Hoffman, Peter Louis, *Los Angeles*
Hubbard, Cleon K., *Legion, Texas*
Kellogg, William A., *Long Beach*
Kettenbach, Floralou, *Los Angeles*
Le Tuorneau, Norman H., *Glendale*
Leviton, Max I., *Los Angeles*
Lieberman, Herman S., *Beverly Hills*
Lipkis, Maurice Leonard, *Beverly Hills*
Macklet, Helen, *Los Angeles*
Marcot, Neal A., *Los Angeles*
Mazur, Harold, *Los Angeles*
McClelland, Preston H., *Santa Monica*
McIntosh, Thomas William, *Pasadena*
Moshos, Don Carlos, *Torrance*
Murphy, Clarence F., *Pasadena*
Nardini, Harry M., *Los Angeles*
Nicholson, Roscoe M., *Los Angeles*
Nystrom, S. Robert, *Glendale*
Pies, Morris, *Los Angeles*
Puttler, S. D., *Alhambra*
Quillen, Lawrence J., *Alhambra*
Roberts, Walter L., *Los Angeles*
Rodi, Albert H., *Los Angeles*
Rosen, Samuel, *Los Angeles*
Sapiro, N. A., *Beverly Hills*
Scarborough, Marianne, *Los Angeles*
Schillinger, Robert J., *Los Angeles*
Shepard, Lyle, *Glendale*
Silver, Abraham Joshua, *El Monte*
Smith, Hershel I., *Huntington Park*
Spickerman, Harold DeWitt, *Los Angeles*
Stout, Orin Milton, *Los Angeles*
Test, William B., *West Los Angeles*
Troxler, Eulyss Robert, *Los Angeles*
Tutunjian, Khacher H., *Los Angeles*
Van Buskirk, James Dale, *Los Angeles*
Watson, Blake Halverson, *Los Angeles*
Weil, Hans Joseph, *Altadena*
Whittier, John Coburn, *Glendale*
Wilson, John Walter, *Los Angeles*
Wunderlich, Edwin E., *Los Angeles*
Yengst, Henry L., *North Hollywood*
Zell, Harry J., *San Marino*

Orange County (2)

Pease, George Norman, *Corona Del Mar*
Saylin, Joseph, *Orange*

San Bernardino County (1)

Grow, Walter L., *San Bernardino*

San Diego County (5)

Barton, Robert E., *San Diego*
Ing, Henry, *San Diego*
Turkus, Edward Newton, *Vista*
Walter, F. J., *San Diego*
Werelius, W. R., *National City*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

San Francisco County (5)

Bayer, Leona Mayer, *San Francisco*
Bernhard, Russell W., *San Francisco*
Fishman, Louis Zolo, *San Francisco*
Gara, George, *San Francisco*
Griswold, Herbert Edward, Jr., *San Francisco*

Sonoma County (2)

Robinson, Clinton W., *Santa Rosa*
Young, Edith F., *Sonoma*

Ventura County (1)

Monahan, John R., *Oxnard*

Transfers (7)

Curphey, Wilfred C., from Marin County to San Joaquin County.
Hanssen, Egil, from San Bernardino County to Los Angeles County.
Loewenberg, Richard D., from Lassen-Plumas-Modoc County to Kern County.
Lord, Dorothy, from Butte-Glenn County to Los Angeles County.
Merret, Russell, from Siskiyou County to San Francisco County.
Pennes, Alexander H., from Orange County to Los Angeles County.
Rogers, Arthur E. T., from Tulare County to Los Angeles County.

In Memoriam

Bahrenburg, George Edward. Died at Bakersfield, December 20, 1944, age 64. Graduate of the University of Southern California, School of Medicine, Los Angeles, 1903. Licensed in California in 1903. Doctor Bahrenburg was a member of the Kern County Medical Society, the Califronia Medical Association, and a Fellow of the American Medical Association.

✣

Schlageter, Herman Joseph. Died at San Francisco, January 19, 1945, age 73. Graduate of the Cooper Medical College, San Francisco, 1895. Licensed in California in 1895. Doctor Schlageter was a member of the San Francisco Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Smith, Bertnard. Died at Los Angeles, January 23, 1945, age 66. Graduate of the Rush Medical College, Illinois, 1903. Licensed in California in 1906. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Taubles, Gustave Herman. Died at Carmel, January 24, 1945, age 65. Graduate of the Cooper Medical College, San Francisco, 1908. Licensed in California in 1908. Doctor Taubles was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Wemple, Emmet Leroy. Died at Verdugo City, February 10, 1945, age 70. Graduate of the University of California Medical School, Berkeley-San Francisco, 1900. Licensed in California in 1900. Doctor Wemple was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA PHYSICIANS' SERVICE†

Board of Trustees

Ray Layman Wilbur, M.D., President, Stanford University
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C.P.S. Beneficiary Members

	December 1943	*December 1944*
Commercial Program	58,508	107,000
Rural Health Program	2,400	2,045
War Housing Program	20,675	15,000
Total Membership	81,673	124,045

* * *

Some of the investments that the medical profession has made through the medium of reduced fees during the formative periods of C.P.S. may now be returning some dividends.

In the current upheaval of the medical situation in California, there are all kinds of proposals being loosely flung around. There are violent discussions regarding the methods of the rendition of medical care. There are the fee for service, capitation and group methods. Also looming on the horizon, more and more, there is the cost of medical care under any of these systems. The Governor's bill admits that they are not quite sure that the 1½ per cent from the employee plus the 1½ per cent from the employer will be sufficient to cover costs, in that the bill will open the State Treasury to any possible deficit. Most of the other bills have been based on theoretical assumptions that have probably originated from study groups of the C.I.O. research committees who, in part, may have drawn upon the advice and counsel of foundations, academic resources and Social Security or Public Health Service statistics. Or they may have drawn upon some isolated experiment, or a going plan or plans covering limited numbers of people in restricted geographical areas and under special conditions.

All of these conceptions of the cost of medical care have not been put to an actual test from a practical point of view. It is well-known to California Physicians' Service that theoretical conceptions of the cost, based on the best information obtainable, have resulted on many occasions in unsatisfactory experience when put to an actual test. It is a well-known fact among people interested in medical administration that it takes more than analytical research juggling available figures to predict costs under any program. There is always present the unknown quantity of the human reaction to any plan. The effect of this can only be obtained by actual experience and exposure to the people who are to receive the care as well as to the physicians who will render that care.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M.D., Secretary.
Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

C.P.S. has been called upon in the past to reveal its experience. It has done so before the Pepper Committee in Washington, and the information given there has made a genuine impression, and it is reasonable to believe that it has caused thinking relative to medical care plans to become a little bit more practical. This could be a very healthy sign in a subject that has been almost universally approached from purely an emotional point of view. In our own State, under present legislative proposals, the six years of experience of California Physicians' Service, with all of the factors of medical care being exposed on the day-to-day basis during this time, and the handling of several hundred thousand people, must certainly appeal to those legislators and other interested people who would approach this subject with an open mind and with mature judgment as being of great significance. It cannot be by-passed.

Along these lines, C.P.S. was able to turn over to the California Medical Association a large wealth of such information, and it is currently being used in the discussions of the various health plans. The latest reports from the Assembly hearings indicate that it is carrying considerable weight and stimulating these people to perhaps another line of thinking. C.P.S. has sufficient information accumulated over a long enough period of time and in sufficient volume, of different experiments in medical care with the Commercial, War Housing and Rural Health Programs, so that it is able to predict the costs under various methods of rendition of medical care, whether it be fee for service, capitation or group service.

All of these have led to the inescapable conclusion that modern medicine has far out-jumped the guesses of those who were talking in terms of 3 per cent payroll deductions, some 10 to 15 years ago. The cost of American Medicine, as it has developed scientifically through slow evolution, has been clearly demonstrated. This information alone, which no one can controvert with any similar data other than pure theoretical assumptions, may be one of the great contributions C.P.S. will make to the practice of medicine in the State of California.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Accident Reduction

National Safety Council's Contribution to War Effort By Saving of Millions of Man-Hours

The National Safety Council has made a substantial contribution to the nation's war program. Its three years of constant campaigning to reduce accidents in industry and in the home has resulted in the saving of millions of man-hours, and has furthered our production to that extent.

It is good news that the campaign, supported by the contributions of business and industry, is to be continued, and that a fund of $1,000,000 will be sought with which to carry on this important educational work during 1945.

There has been steady improvement in the national accident rate since the council's program was put into effect. Last year there were 3,500 fewer accidental deaths than in 1943, and there was, in addition, a decrease in the number of non-fatal accidents.

This saving in manpower prevented a possible breakdown in some channels of essential industry; it reduced potential fire losses, and it preserved unmeasurable quantities of equipment and supplies from damage or destruction. These are indeed huge results.

"Until about three years ago," says a bulletin from the Council, "safety work in this country was confined largely to the fields of industry and traffic, with the result that no strongly organized effort was being made to prevent about half of our accident losses. When it is considered that these losses amounted to nearly 100,000 people killed, 9,000,000 injured, 350,000 permanently disabled and a $5,000,000,000 economic loss every year, it seems obvious that some serious effort to bring the situation under control was inevitable."

The National Safety Council's public service program represents the first organized effort to be directed against all types of accidents, both on-the-job and off-the-job. It is conducted on a coast-to-coast basis, through the national and four regional offices and by local chapters, one of which is in San Francisco.

While its organization resulted from business and industry accepting for themselves a special and added responsibility to assist the nation in time of war, it is to be hoped its efforts will not terminate with the coming of peace. There will always be a need for this important work.

Disease Observes No Geographical Boundary Lines

Health is something that all nations desire, and no nation by the process of gaining it takes it away from another. There is not a limited supply of health for which nations must compete. Rather, every nation by promoting its own health adds to the better health of other nations, just as by assisting in the public health efforts of other nations we protect ourselves.

Here is a field of common interest to the race of man everywhere on the planet. Interpreted in broad, positive terms to embrace physical, mental and moral fitness, it can be a nucleus of international activity which will encourage emulation in other and more difficult fields.

* * *

What the League of Nations did in Geneva through its International Health Organization can be the starting point and basis of a far broader and better supported work.

A new worldwide epidemiological intelligence system, the standardization of biological products, the organized exchange of public health personnel to broaden the technical outlook and stimulate the imagination of health officers, the supplementation of public health activity in countries where it is inadequate, the development of minimum standards of acceptable public health work that can be applied on a worldwide basis, the creation of commissions of experts and international conferences on such subjects as malaria, yellow fever, rabies, nutrition, housing, rural hygiene, physical education, social security —these are only samplings of the activities which could profitably be pursued, prehaps on a regional basis, by a new International Health Organization.

* * *

Work in public health which disregards flags and boundary lines has become in our generation essential to the safety of the human race everywhere. Public health can no longer be thought of exclusively in national terms. In a world as closely knit as ours, what menaces one country menaces another, whether it be disease or disaster.

Take, for example, the yellow fever situation. There has never been any yellow fever in India or in the Orient, and consequently no immunity against the disease has been built up, as in Africa and South America. India is therefore a tinderbox, and a single infected mosquito could break down all the barriers of quarantine, vaccination and medical vigilance.

* * *

No nation by its own acts alone can protect itself from such an overshadowing menace. It requires united, coöperative action in which boundary lines are overlooked and conceptions of sovereignty are relegated to the limbo of forgotten things.

The gambiæ mosquito furnishes another illustration. For centuries it has been the scourge of Central Africa

Until 1930 this mosquito was unknown on this side of the Atlantic. But a new line of planes began to bring passengers to Brazil and the gambiæ came along, too: the terror of that visitation is deeply engraved on the memory of northeast Brazil.

This poses a problem which cannot be evaded. The safety of the Western Hemisphere, now within a few hours' flight across a narrow ocean, can no longer be left to the uncertainties of a flit gun campaign. If the Americas are to be protected adequately, the breeding places of gambiæ, wherever they may be found, must be eradicated or controlled. The campaign must be carried to the sources of infestation. It must be offensive.

This newly made world which the airplane has tied together has lost its frontiers. Whether we like it or not, the propinquity of modern life now confronts us with inescapable demands for new techniques. We are living in the Twentieth Century and we cannot retrace our steps back into the Nineteenth. Our only hope of survival lies in collaboration across boundary lines.—From an address by Raymond B. Fosdick, president of the Rockefeller Foundation, reprinted in the American Journal of Public Health and in the Fresno *Bee*, January 21.

(COPY)

Los Angeles City Health Department

COMMUNICABLE DISEASES TO BE EXCLUDED FROM SCHOOL

Disease	*Incubation Period*	*Exclusion Period of Patient*	*Exclusion Period of Contacts*
Chickenpox	14 to 21 days	For 7 days after appearance of the rash and all scabs off	None if patient is properly isolated
Conjunctivitis (pink eye)	1 to 5 days	Recovery	None
**Diphtheria*	2 to 7 days	8 days followed by 2 negative nose and throat cultures taken 48 hours apart, from City Health Laboratory	7 days and 1 negative culture from the nose and throat, from City Health Laboratory
Diphtheria Carrier		Until 2 negative cultures of the nose and throat, 48 hours apart	1 negative nose and throat culture
Dysentery (Bacillary)	2 to 7 days	Same as typhoid. Release specimens 3 days apart	None
Encephalitis (Infectious)	4 to 14 days	7 days from onset	None if patient is properly isolated
German Measles	14 to 21 days	Recovery	None
**Gonococcus Infection*	3 days or more	Until non-infectious	Health officer decides
Influenza	Up to 2 days	Recovery	None
Impetigo	Short	Recovery	None
Jaundice Infectious	One week	Recovery	None
Measles	9 to 12 days	At least 7 days after appearance of the rash	None if school medically supervised inspection available
**Meningitis (Meningococcic)*	2 to 10 days	14 days from onset and clinically well	14 days from last contact
Mumps	8 to 30 days	Swelling completely subsided	None
Pneumonia (Infectious)		Until 5 consecutive days of normal temperature	None
**Plague*	5 to 7 days	Health officer decides	Health officer decides
Psittacosis	6 to 15 days	Recovery	None
**Poliomyelitis*	3 to 14 days	14 days from onset and clinically well	14 days from last exposure
Pediculosis	Unknown	Recovery	None
Ringworm	Unknown	Recovery	None
Scabies	Unknown	Recovery	None
**Scarlet Fever*	2 to 7 days	21 days from onset and clinically well	7 days from last exposure
Septic Sore Throat	1 to 3 days	Recovery	None
**Smallpox*	8 to 21 days	Recovery and crusts or scabs disappear	Until immunity established
Syphilis		Until non-infectious	Health officer decides
Trachoma	Unknown	Health officer decides	None
**Tuberculosis*	Slow	Health officer decides	None
Typhoid and Paratyphoid	7 to 23 days	5 days normal temperature and 2 negative stool and urines, 5 days apart	None. Should be immunized.
Typhus Fever	5 to 20 days	Recovery	None
Whooping Cough	7 to 10 days	21 days from appearance of paroxysmal cough or until complete recovery	None if school medically supervised inspection available
**Yellow Fever*	2 to 6 days	4 days after onset of fever	7 days from last exposure

Dog Bites: Reportable; immediate cauterization, with fuming nitric acid, and neutralization with sodium bicarbonate solution, important.

Food Poisoning: Report at once by telephone—MIchigan 5211, Station 424.

NOTE: All infectious diseases (food poisoning included) must be reported promptly. Your coöperation will be appreciated.

Any child absent from school on account of illness for five days or more (Saturdays and Sundays included) MUST HAVE A RE-ADMITTANCE CARD before being permitted to reënter school. In the case of all or any diseases that have been quarantined, and in the case of all diseases indicated by an asterisk, re-admittance card must be issued by a Health Department official only. In all other cases, any registered physician, surgeon, or school nurse may issue re-admittance cards, subject to the discretion of the Health Officer. A pupil who has been absent from school for a period of more than five days (Saturdays, Sundays and Holidays included), on account of a minor illness, KNOWN TO BE NON-CONTAGIOUS, may be readmitted by the principal, except during an epidemic period.

GEORGE M. UHL, M. D.,
Health Officer

Form E-47

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

See editorial comment, in this issue.

American Medical Association. The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10.15 a. m., under the title, "Your Doctor and You."

In March, KFAC will present these broadcasts on the following Saturdays: March 3, 10, 17, 24, and 31.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Symposia:* Covering all phases of nutrition, and led by Sir Edward Mellanby (*Brit. Med. Bull.*, 2:202-254, 1944). Very important one sponsored by New York Academy of Science on energy relationships in enzyme reactions, by J. S. Fruton, E. G. Ball, M. Bergman, H. M. Kalckar, O. Meyerhof, and C. V. Smythe (*Ann. N. Y. Acad. Sci.*, 45:357-436, 1944). N. Y. Academy holding important one on hypertension, Feb. 9 and 10, at American Museum of Natural History, N. Y. F. A. Lawes and B. Williams hold forth on fatigue (*Med. J. Austral.*, 2:501-507, Nov. 11, 1944).

2. *Gas:* Look carefully into E. N. Harvey & Co.'s important studies on bubble formation in animals (*J. Cell. Comp. Physiol.*, 24:1, 23, 117, 133, 257, 273, 1944). J. W. Bean fully reviews effects of oxygen at increased pressures (*Physiol. Rev.*, 25:1, 1945).

3. *Cancer:* Add symposium by staff of Barnard Free Skin and Cancer Hospital (*Surg. Clin. North America,* Saunders, Philadelphia, 1944, pp. 981-1268). R. Leuchtenberger & Company report "folic acid" (L. casei factor) IV injections cause regression and prevention of spontaneous mouse breast cancers (*Science,* 101:46, Jan. 12, 1945). V. R. Potter & Co. show that energy metabolism enzymes increase 3 fold after birth (*Cancer Res.*, 5:21, 1945). Note M. J. Shear & Co.'s series of articles on chemical treatment of tumors with hemorrhage producing polysaccharide from Serratic Marcescens (B. prodigiosus). These are summarized in clinical report (*J. Nat. Cancer Inst.*, 5:195, 1944), and refer to W. B. Coley's work (*Glasgow M. J.*, 126:49, 128, 1936) and G. Schwartzman's *Phenomenon of Local Tissue Reactivity* (Hoeber, N. Y., 1937; *Cancer Res.*, 4:191, 1944). F. Duran-Reynals shows importance of host resistance factors in enoplastic reactions to rabbit fibroma virus (*Cancer Res.*, 5:25, 1945). J. P. Greenstein and F. M. Leuthardt describe degradation of cystine peptides by exocystine desulfurase (*J. Nat. Cancer Inst.*, 5:209, 1944; *Science,* 101:19, Jan. 5, 1945). F. E. Chidester writes on *Nutrition and Cancer* (Lancaster Press, Pa., 1944).

4. *Therapy:* L. Loewe recommends combined use of penicillin and heparin in subacute bacterial endocarditis (*Canad. Med. Asso. J.*, 52:1, 1945). A. F. Coburn discusses control of streptococcus hemolyticus (*Mil. Surg.*, 96:17, 1945). L. W. Smith and A. E. Livingston recommend 1 per cent chlorophyll ointment containing 250 units penicillin per gram for promotion of wound healing (*Am. J. Surg.*, 57:30, 1945). D. Greiff & Co. find paraamino bensoic acid orally effective vs. murine typhus in mice, and PBA and penicillin rickett-siostatic, while NaF1 is the reverse! (*J. Exp. Med.*, 80:561, 1944). F. M. Allen summarizes treatment of surgical shock and embolism by preventing fluid loss, replacing fluid lost, and local and general refrigeration (*J. Internat. Coll. Surg.*, 7:423, 1944). Note H. McIlwain on theoretical aspects of bacterial chemotherapy (*Biol. Rev. Cambridge Philosoph. Soc.*, 19:135, 1944).

5. *Furthermore:* J. W. Bartholomew and W. W. Umbreit report that ribonucleic acid with magnesium and cell protein is responsible for gram positive staining, and that sulfhydryl groups are involved (*J. Bact.*, 48:567,

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

1944). C. Pinto recommends saponin for efficient and economical killing of snail carriers and cercaria of Schistosoma in streams (*Mem. Inst. Oswaldo Cruz*, 40:210, 1944). B. D. Davis discusses variety of biologic false positive serologic tests for syphilis (*Med.*, 23:359, 1944). R. M. McKenna notes psychosomatic factors in skin disease (*Lancet*, 2:679, Nov. 25, 1944). In swell discussion of structure and permeability of blood capillaries, J. F. Danielli and A. Stock conclude most substances reach tissue cells after filtration through pores in intracellular cement, and that edema follows Starling's hypothesis of protein gradient in pericapillary fluid and Poiseuille's equation that rate of flow is proportional to 4th power of capillary radius (*Biol. Rev. Cambridge Philosoph. Soc.*, 19:81, 1944). Note our E. H. Frieden's report on diffusion constant of penicillin suggesting molecular weight of 490 (*Science*, 101:21, Jan. 5, 1945). Also F. T. Maher's *Reticulo-Endothelial System in Sulfonamide Activity* (Univ. Illinois Press, Urbana, 1944, $3.50). And S. Drake's discovery of A. B. Johnson and his works on language (*Rev. Gen. Semantics*, 1:239, 1944). While R. A. Woodbury and B. E. Abreu say yarns and sighs increase venous return, getting blood back to tired heart, ho-hum (*Am. J. Physiol.*, 142:721, 1944).

Erroneous Insertion of Advertisement in Text Department.—Owing to an error in the bindery division of the Wolfer Printing Company, printers of California and Western Medicine, a colored advertisement was placed between text pages 36 and 37 of the January issue. The advertising announcement was marked for placement in the back advertising section, between pages *36* and *37* of that department. Printers have expressed their regret concerning the error.

Forty-two Conscientious Objectors Risk Pneumonia.—Experiments with forty-two conscientious objectors, some of whom were inoculated with throat washings from soldiers having atypical pneumonia, have demonstrated that a virus can cause this kind of pneumonia, an Army medical commission reported on January 18.

All the conscientious objectors volunteered for the expermients. They were segregated in individual rooms in a hotel under rigid quarantine for eight weeks.

The inoculations consisted of throat washings and sputum from six patients having atypical pneumonia, which is not typical pneumonia or not like pneumonia caused by bacteria.

Recent studies have shown, the article said, that bacteria, fungi and virus, particularly those of the psittacosis or parrot fever group, may produce a group of symptoms of a disease sometimes called "virus" pneumonia.

Some of the throat washings were filtered through a glass which eliminates all bacteria, but three of the twelve receiving this bacteria free filtrates became sick with primary atypical pnuemonia. Twelve men were inoculated with unfiltered material and the same number became ill.

"The results of this experiment thus demonstrate that bacteria free filtrates, presumably containing a virus, can induce primary atypical pneumonia in man," the physicians of the Army Medical Department at Fort Bragg, N. C., concluded.

Training for Hospital Librarians.—The School of Library Service at Columbia University will offer in the summer session of 1945 a program pertaining to work in hospital libraries, running from July 2 to August 10. This is in response to a growing demand, and to a prospective expansion of such work in government hospitals.

Enquiries and requests for application forms may be addressed to the School of Library Service, Columbia University, New York *27*, New York.

Stanford University School of Medicine: Department of Pharmacology.—Dr. Wei Chang Chu, instructor in pharmacology, Kweiyang Medical College, arrived in San Francisco, January 24th, on leave for two years from the Chunking Government, for work in the department of pharmacology, Stanford University School of Medicine. Dr. Chu is a graduate of the Hunan-Yale Medical College, 1937.

Mayo Memorial Fund.—Plans for erecting on the University of Minnesota Medical Campus a center for medical research, teaching and adminstration as a Memorial to Doctors William J. and Charles H. Mayo have been announced by the Committee of Founders of the Mayo Memorial appointed by Governor Edward J. Thye and headed by Dr. Donald J. Cowling, President of Carleton College.

The proposed 12-story Mayo Memorial building to be erected in the center of the University Hospitals quadrangle will be constructed at a cost of $2,000,000. The committee visualizes the Memorial as contributing much to the general public, to industry, to practicing physicians, to nurses and to medical students.

It will contain a Memorial auditorium, research laboratories, conference rooms for clinical departments, and the department of Pathology, the operating rooms and major labofatories of the University Hospitals, the administrative offices of the Medical School, the School of Nursing, the University Hospitals and the Department of Post Graduate Medical Education. By assembling these and other facilities under one roof the Mayo Memorial will create in fact a great medical center where research, training and treatment go forward hand in hand every minute of every day—thus carrying on through many generations the work so nobly advanced by the Mayos.

The Committee of Founders believes that all friends of the Doctors Mayo will wish to help make the Memorial a reality. There will doubtless be many others who may not have known the Mayos personally but who know of their remarkable work and will desire to participate in this tribute.

Further details on the proposed Memorial and a descriptive booklet may be obtained by writing to the Mayo Memorial Fund, 1126 N. W. Bank Building, Minneapolis *2*, Minnesota.

A Tribute to the Country Doctor.—Last spring a woman of culture left her home in one of America's principal cities to spend six months in Arkansas. Soon after her arrival she came down with a common ailment and needed a surgeon. Her new neighbors almost failed to convince her that the village doctor was safe to consult. She asked: "If he's so wonderful, what's he doing here? A really good doctor can make a lot of money in a city."

She was right on *one* point. This doctor *could* make a lot of money in a city. He has not fared poorly where he is, but he never will be rich. He is not so much interested in money, however, as in a certain kind of success that's not measurable in dollars. He has a priceless estate of human lives. He can't leave his house without meeting people who owe their very existence to his skill.

A Rich Estate

This country doctor has the unfeigned love of his

neighbors. His work and ethics have their unqualified approval, but that's only part of the story. He likes *them* too. Nobody suffers for medical attention where he lives. "He gets paid for it," do you say? Yes, he collects from about half his patients. But the humblest sharecropper can have the best doctor he ever heard of, and never see a bill.

Writing this, I have a particular physician in mind, but I'm satisfied you are thinking about another doctor as you read it. There is one in just about every country town; two or three in big places. America still has plenty of neighborhoods where men grow up and live to a ripe old age at one address. These are the spots where a doctor is a real person, not just a service.

The Case History

Knowing the people in his neighborhood is worth a great deal to a physician's success. Even a specialist, who treats strangers almost exclusively, will agree that a patient's history is more helpful to the doctor than an examination. That's why I don't want to swap doctors with you, and I hope you feel the same way. Together, we can save this country from the political curse of socialized medicine.

A firm protest from the forks of the creek, mountain coves and farming towns can keep the Wagner National Health Bill, now decomposing in a pigeon-hole of a Senate subcommittee, from ever coming to life. It was introduced with small hope of passage, its chief purpose perhaps was to raise the issue and start people talking about medical service as something to be standardized and rationed like gasoline.

My doctor is a busy man. He works more nearly 16 hours a day than eight. A standardized working week of, say, 40 hours for him would make two new doctors in our neighborhood necessary. Of course both new men would have to study the community's health record, have to be as well schooled as the older doctor and have to receive suitable salaries.

It would be a bad deal, three ways:

1. Some of my doctor's patients would have to accept treatment from a man with all to learn about *them*.

2. Since three men cost more to maintain than one, all of us would spend more money for medical aid.

3. My good doctor wouldn't be busy. This is the worst feature. The work he loves (his estate of lives) would be taken away from him. I figure this agile mind would turn to something else, and that he'd quit being a doctor at all.—George S. Benson, President of Harding College, Searcy, Arkansas, in the Commentator column, "Looking Ahead" in the Sacramento *Commercial News*, December 15, 1944.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Kaiser's Profits

Congressman Says $100,000 Investment in War Industries Yielded Millions

Washington, Feb. 23—(AP.)—Henry J. Kaiser [founder of Permanente Hospitals] founded his war industries on a private investment of $100,000, and two of the firms have shown a profit of $27,274,487, according to a statement entered into the *Congressional Record* by Representative Woodruff (R., Mich.),

"Mr. Kaiser, without a doubt, has done a magnificent job in contributing to the success of our armed forces," Woodruff said in his statement.

"He has displayed a capacity for organization and production that amazes everyone familiar with his record. However, his efforts have not gone entirely unrewarded."

Quoting information he said he obtained from the Comptroller General's office, Woodruff's statement said the profit figure was after contract renegotiation but before taxes and added:

"It seems, Mr. Speaker, that when the reports on the other companies are finally in it will be found that the original $100,000 investment was a decidedly profitable one."

Woodruff said the Government had spent $216,647,743 in providing facilities for seven Kaiser companies, and "it will be noted that the original investment of the Kaiser group was $100,000."

Woodruff told a reporter he referred only to the Kaiser "war babies"—companies set up beginning in 1941 to handle war contracts—when he spoke of the original private investment.

Some Kaiser companies were operating long before the war began, but Woodruff said he is not concerned with their cost, investment or profits.

With his statement, Woodruff put in the record a detailed report from the Comptroller General's office on the financial structure of these associated Kaiser companies—California Shipbuilding Corporation, Kaiser Cargo, Inc., Marinship Corporation, Oregon Shipbuilding, Permanente Metals Corporation, Richmond Shipbuilding Corporation, and the Walsh-Kaiser Co., Incorporated.

The report showed renegotiated profits before taxes through 1943 of $16,551,324 for the California Shipbuilding Corporation, and of $10,723,163 for the Oregon Shipbuilding Corporation. Profits for the other five companies were not listed.—San Francisco *Chronicle*, February 24.

Warren Denies Housman Plea

Governor Refuses to Pardon Former S. F. Doctor

Attempts of Nathan S. Housman, former San Francisco physician, who served a prison term for perjury, to obtain a pardon and restoration of his medical license suffered a sharp setback on February 16 at the hands of Governor Warren.

Taking direct issue with Superior Judge Lile T. Jacks of San Francisco, who recommended "rehabilitation" of Housman, the Governor refused to pardon the former physician.

The Governor pointed out that in his recommendation Judge Jacks had gone counter to the law, which specifically provides that a petition for rehabilitation cannot be filed until the petitioner has lived continuously in the county of filing for at least three years before filing.

Housman, the Governor recalled, was paroled on December 18, 1942, and Judge Jacks granted him a certificate of rehabilitation on October 16, 1944—a period considerably less than the minimum required by the law. Said the Governor:

"In my opinion, a sufficient time has not elapsed to demonstrate Doctor Housman's rehabilitation, nor has he satisfied the statutory requirement of three years' residence. For these reasons, I have denied Doctor Housman's application for pardon."

The denial is expected to exert decisive influence over the decision of the State board of medical examiners, which will hear Housman's petition for restoration of license at Los Angeles on February 27. Doctor Housman's license was automatically revoked when he was convicted of a felony—two counts each of perjury, offering false evidence, and preparing false evidence.

These offenses occurred during trial of a misdemeanor charge against Doctor Housman: Omitting to keep proper records of narcotics prescriptions.—San Francisco *Examiner*, February 17.

Work Insurance

Economist Asks Living Wage, Medical Care, Job Guarantee

Washington, Feb. 18.—A post-war Government guarantee of a job for every person able and willing to work, as well as a guaranteed minimum living standard, was proposed today by a Federal economist.

E. A. Goldenweiser, chief economic adviser to the Federal Reserve Board and with the board for 26 years, advanced both ideas in a suggested program aimed at 58,000,000 postwar jobs.

"If a person has done all he can to find a job and still can't find one, the Government ought to offer him a job," the economist said, in the current issue of the Federal Reserve Bulletin. . . .

"We have a kind of minimum now in that we don't intend to have anyone starve or freeze or go without shelter, but it differs too widely.

"It depends too much on the disorganized action of individuals and groups.

There should be established a standard of living below which no person in this country needs to fall under any circumstances; a minimum of food, a minimum of clothing, and minimum of shelter, education *and medical care and even of money.*"—San Francisco *Chronicle*, February 19.

College Heads Ask Delay in Post-War Training

Twelve leading educators, including the presidents of Stanford and the University of California, said recently in a letter to President Roosevelt that it would be unwise and dangerous to commit the nation to compulsory post-war military training "under the tension of war psychology," the United Press reported from Washington.

They urged him to delay at least until Germany is defeated his proposed message to Congress requesting a year's training for all youths so the people can reach "a wise decision . . . after a cool debate."

Suggesting that prohibition had demonstrated the danger of trying to decide long-range policies in wartime, the educators said proponents of military training show a distrust of the people when they argue it wouldn't be adopted unless Congress acts under the stress of war.

"It is to imply that the people cannot arrive at a wise decision on a great issue through the democratic processes," the letter said. "With the great body of Americans, we all will support a year of compulsory training if, after adequate deliberation, the nation is convinced that its safety requires it."

The letter was signed by the presidents of 12 universities—James B. Conant, Harvard; Oliver C. Carmichael, Vanderbilt; Edmund E. Day, Cornell; Harold W. Dodds, Princeton; Rufus C. Harris, Tulane; Robert M. Hutchins, University of Chicago; Frederick A. Middlebush, Missouri; Deane W. Malott, Kansas; *Robert G. Sproul*, California; *Donald B. Tresidder*, Stanford; Herman B. Wells, Indiana, and Henry M. Wriston, Brown.

Denouncing the post-war training proposal as nothing more than "peacetime conscription," they set forth these arguments in opposing it at the present time:

1. It is not related to the successful prosecution of the war.

2. Its adoption would be a revolutionary change in fundamental American policies, a move that would be "extremely unwise and even dangerous" until the post-war international situation is clarified.

3. Peacetime training is only one phase of a rounded defense program and "to adopt it under the stress of war and have it prove unwise might jeopardize an intelligent long-run defense program."

4. It is impossible to "determine intelligently" the extent of defense measures that will be needed after the war since "no one can now foresee the international situation when the war is over."

5. "The people are fighting the war with high hope it will eventuate in an enduring peace. If Congress should now prescribe a year of compulsory military training, the action together with the necessary accompanying measures for mobilizing industry and science would be interpreted as meaning that we must continue to live for an indefinite period in an armed camp."—San Francisco *News*, January 31.

Harry Hopkins Urges Compulsory Military Training

Washington, Feb. 1.—(UP.)—Harry L. Hopkins, President Roosevelt's right hand man and often the unofficial but on-stage voice of Administration policy, today called for compulsory military training of American youth as a standing menace to future German and Japanese aggression

Writing in the current issue of *American Magazine*, he said:

"I have no doubt that powerful forces in Germany and Japan are preparing even now for their next attempt to conquer us. We will try to keep them impotent, but only a perpetual army of occupation would be able to prevent them from rearming eventually." . . .

Compulsory military training should include every 18-year-old boy, omitting only those who are incapable of mental or physical rehabilitation he said. Married youths, 4-Fs and "necessary' workers must be included because the American people will not approve a program which permits some youths to "appear to be ahead of their friends who return from training camps."

He rejected the idea that a year of training would turn the Nation into a military machine made up of regimented men and create a Hitler-like youth movement. On the contrary, he said, boys would be taught trades, illiterates would learn to read and write and "thousands who are ailing, thousands who can be rehabilitated by operations, will be made well."

Congress should pass a law providing for compulsory training, he said, but only after "thorough consideration of every objection that can be advanced."

"This is no time to rush through a law that may inspire increasing opposition," he wrote. "If we inaugurate a kind of military training that fathers and mothers decide is doing their boys no good, the people will abolish it after a few years—to the delight of our enemies."—San Francisco *Chronicle*, February 2.

Draft All Nurses, Parran Urges

Washington, Feb. 6.—(INS)—Surgeon General Thomas Parran today recommended to Congress that all nurses be placed under Selective Service and required to perform essential civilian as well as military tasks.

The head of the U. S. Public Health Service, speaking in favor of nurses' draft legislation, told the House Military Affairs Committee:

"We should have a real Selective Service under which each nurse would be required to contribute in proportion to her skill on the military or civilian front."—San Francisco *Call-Bulletin*, February 6.

Nurse Draft Approved by House Representatives

Washington, Feb. 27.—(IN.)—The House Rules Committee today approved the Nurses' Draft Bill, thus clearing away the last obstacle to a vote in Congress, probably later this week, on precedent breaking legislation to induct women into the armed services.

Favorable action was spurred when Representative May, Democrat of Kentucky, chairman of the House Military Committee, disclosed that approximately 515,000 servicemen are now hospitalized; 285,000 in hospitals overseas and 230,000 in this country.

"Some 1,600 men are pouring into field hospitals from the front every twenty-four hours," May told the committee, "or about 11,000 to 15,000 each week, and the number is increasing. In addition, there are another 6,000 men a day who require treatment but no nursing care.

"The need is imminent and imperative." . . .—San Francisco *Examiner*, February 27.

8,000 WACs Needed for 63 Hospitals

A new and vigorous drive to recruit some 8,000 WACs for service in the 63 Army general hospitals in the country was inaugurated on February 10th.

Women qualified for training as medical and surgical technicians, clerical and other skilled workers are urgently needed to fill these hospital units to aid in rehabilitation of returned soldiers.

Under the plan, outlined last week by General George C. Marshall, a company of 100 women is to be assigned to each of the 1,000-bed hospitals and an additional company of the same size for each additional 1,000 beds in the larger institutions.

Qualified women enlisted as medical and surgical technicians will be assigned to a hospital unit as students after six weeks of basic military training and six weeks at an enlisted technicians' school. They will receive one month of applicatory training after assignment to the hospital. Upon completion of this training they will qualify as technicians with appropriate Army ratings and will continue on duty at the place of their final training.

Letterman General in San Francisco and Dibble General hospitals are preparing to receive the first companies of local WAC medical technicians. Other hospitals in the area eligible for WAC companies are Hammond General in Modesto and DeWitt General at Auburn.—San Francisco *Chronicle*, February 11.

New Discharge Plan Bared

Victory in Europe to Free 200,000 Month

Washington, Feb. 27.—(AP.)—War Department plans to release from 200,000 to 250,000 men a month after the war needs in Europe were disclosed on February 26th.

Brig. Gen. Frank T. Hines, head of the Veterans' Administration, made the disclosure while testifying before the House Appropriations Committee on a deficiency bill sent to the floor today. . . .

The present rate of discharges, Hines asserted, is running around 90,000 monthly. Approximately 700,000 of the 1,600,000 released up to last November 30, he added, were discharged under certificates of disability.—San Francisco *Examiner*, February 27.

Veterans Need Expanded Health Program, Senator Pepper Says

Washington, Feb. 25.—(AP.)—A Senate subcommittee estimated today that between 1,500,000 and 2,500,000 Americans will incur disabilities in the war, and urged that existing health facilities and programs be greatly expanded.

"The men and women in the services have been accus-

tomed to the best in medical and hospital care," said Senator Pepper (D., Fla.), chairman of a subcommittee on wartime health and education which made the report.

"They will not be satisfied with anything less than the best when they return to civilian life."

The subcommittee recommended that the veterans' administration be given responsibility for the medical care of veterans with service connected disabilities, with chief responsibility for the medical care of an estimated 13,000,000 veterans without such disabilities resting on their own communities.

The report suggested that present laws be revised to make it possible for veterans with service connected disabilities to obtain hospitalization and out-patient treatment not only for their service-connected ailments, but for any other disability as well.

Because the committee considers community hospital facilities generally inadequate, it recommended that the Government continue to offer hospital care for any veteran who needs it, when facilities are available and he is unable to pay for private hospitalization.

The Senators estimated that veterans of the current and previous wars, together with their families, eventually may comprise about one-half of the Nation's population. —San Francisco *Chronicle*, February 26.

X-Ray Center Opens in San Francisco

An x-ray chest survey center, where San Franciscans may obtain a free chest x-ray, has been opened by the San Francisco Tuberculosis Association in coöperation with the department of public health, it was recently disclosed.

The center, located in room 200 of the Public Health Building, 101 Grove Street, is open every morning except Saturday and Sunday from 8 a.m. until 12:30 p.m., Saturday morning from 9 to noon and Monday, Tuesday, and Friday afternoons from 1:30 to 4:30.

Equipment, purchased by the Association with funds raised from sale of Christmas seals, is of the type used extensively by the armed services.—San Francisco *Examiner*.

V.D. Control Program in Industry

Well-established, the principles which the U. S. Public Health Service urges, may be briefed:

I. *Education.*—Planned campaign so that both employer and employee will understand the diseases. . . .

II. *Employment.*—

(a) If a person has infectious VD, he or she should be: (1) Referred to a private physician or clinic for confirmation of diagnosis and treatment; (2) returned to work or employed when rendered noninfectious; (3) persuaded to continue treatment until doctor pronounces the therapy adequate.

(b) If a person has noninfectious VD, he or she could be: (1) Referred to a private physician or clinic for confirmation of diagnosis and treatment; (2) retained on the job.

(c) If late manifestations of the disease are found (such as cardiovascular syphilis, gonorrheal arthritis, etc.): Doctor should recommend person for a job he is physically and mentally capable of doing with safety to himself and fellow workers.

(d) Follow-up: (1) Arrangements made to care for case by treatment by private physician, plant doctor, or clinic; (2) Attending doctor keeps plant doctor posted on regularity of treatment and progress of patient; (3) Refusal to take continued treatment leads to doctor notifying management; (4) Names of infectious cases sent to health dept. for epidemiological investigation.

III. *VD Medical Examination.*—

(a) Recommended for all employees.

(b) Should include serodiagnostic tests for syphilis.

(c) Gonorrhea smears or cultures, when indicated.

(d) Interval: (1) Preëmployment; (2) when doing periodic examinations; (3) return-from-illness examinations; (4) no more than 3 years between examinations.

(e) *Results of examinations are confidential information of the attending physician and plant medical service.*

Does anybody agree with these, act upon them?

If interested in further details on any aspects of VD control in industry, write Otis L. Anderson, Senior Surgeon, Assistant Chief, Venereal Disease Division, U. S. Public Health Service, Bethesda, Maryland.—V. D. *War Letter*.

Use of Mineral Oil in Salads Decried

The increased use of mineral oil in salad dressings, salted nuts, potato chips and doughnuts may have serious nutritional consequences, the state agricultural college said today.

According to Nebraska officials, mineral oil robs the body of at least two of the fat-soluble vitamins necessary to health, and also of two important minerals, calcium and phosphorous.

Mineral oil recently has come into wider use in food preparations, it was said, because it is not rationed, is plentiful, reasonably cheap and does not become rancid.

Studies at Massachusetts, Pennsylvania and Arizona Experimental stations, the officials said, have proven, with tests on rats, that mineral oil offsets the vtaimin A benefits from green salads, butter and cream. Other studies have proven that taking mineral oil greatly decreases the efficiency of cod liver oil in supplying the body with vitamin D. . . .—Brawley *News*.

Interim Report of Pepper Subcommittee on Wartime Health and Education

The American Medical Association announces reprints are now available of the interim report of the Pepper Subcommittee on Wartime Health and Education which was published in the *J.A.M.A.* for January 6. An official copy of that report has been sent from the headquarters office of the A.M.A. to the secretaries, presidents, and chairmen of legislative committees of state medical associations, to officers of the American Medical Association, to members of the House of Delegates of the Association, to members of the Council on Medical Service and Public Relations and to certain others.

Dingell Social Security Bill: H.R. 395

Representative Dingell, of Michigan has introduced in the new Congress H. R. 395, proposing a broad revision of the Social Security Act, including a compulsory system of sickness insurance. The medical provisions of this bill are identical with those contained in the Wagner-Murray-Dingell bill that was introduced in the Seventy-eighth Congress. Up to February 1, neither Senator Wagner nor Senator Murray has introduced a companion bill in the Senate. It is undestood, however, that Senator Wagner has been working on the draft of a new bill, or drafts of new bills, which he intends to introduce in the near future.

Doctor Kirk, Surgeon General of Army, Sees No Drop in Casualties

Major General Norman T. Kirk, Surgeon General of the Army, recently said there was little chance that the casualty evacuation rate of 30,000 to 32,000 men a month from combat theaters would decrease as long as fighting continues.

The men brought back to the United States for hospitalization are only 30 to 40 per cent of the total number wounded, said General Kirk, who visited Letterman General Hospital during an inspection tour.

The 60 to 70 per cent of the wounded are treated and made fit for further combat duties at the theater general hospitals and are returned to their units without a trip to the United States.

The flood of wounded has increased to such a degree that the Medical Corps has been forced to abandon its plans to place the men in general hospitals near their homes, General Kirk revealed.

* * *

Letterman General Hospital, at the Presidio of San Francisco, has also changed its wartime rôle. Now it is the receiving station for overseas casualties from the Pacific who are cared for at Letterman only until they may be routed to the hospital inland where they will receive full care.

"Letterman and its staff is doing a grand job," said General Kirk. The hospital is commanded by Brigadier General Charles C. Hillman. General Kirk served as chief of surgery at Letterman from 1936 to 1940.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Malpractice, Res Ipsa Loquitur

The case of *Ybarra vs. Spangard*, 25 A.C. 479, decided December 27, 1944, by the Supreme Court, involved an action for damages for personal injuries alleged to have been inflicted on plaintiff by the defendants during the course of a surgical operation.

The facts, in the words of the court, were:

"On October 28, 1939, plaintiff consulted defendant Dr. A, who diagnosed his ailment as appendicitis, and made arrangements for an appendectomy to be performed by defendant Dr. B at a hospital owned and managed by defendant Dr. C. Plaintiff entered the hospital, was given a hypodermic injection, slept, and later was awakened by Doctors A and B and wheeled into the operating room by a nurse whom he believed to be defendant D, an employee of Dr. C. Defendant Dr. E, the anesthetist, also an employee of Dr. C, adjusted plaintiff for the operation, pulling his body to the head of the operating table and, according to plaintiff's testimony, laying him back against two hard objects at the top of his shoulders, about an inch below his neck. Dr. E then administered the anesthetic and plaintiff lost consciousness. When he awoke early the following morning he was in his hospital room attended by defendant F, the special nurse, and another nurse who was not made a defendant.

"Plaintiff testified that prior to the operation he had never had any pain in, or injury to, his right arm or shoulder but that when he awakened he felt a sharp pain about half way between the neck and the point of the right shoulder. He complained to the nurse, and then to Dr. A, who gave him diathermy treatments while he remained in the hospital. The pain did not cease, but spread down to the lower part of his arm, and after his release from the hospital the condition grew worse. He was unable to rotate or lift his arm, and developed paralysis and atrophy of the muscles around the shoulder. He received further treatments from Dr. A until March, 1940, and then returned to work, wearing his arm in a splint on the advice of Dr. B."

Plaintiff consulted two other physicians who apparently testified on the trial of the action to the effect that plaintiff suffered from an area of diminished sensation in the region of the shoulder and wasting away of the muscles.

The trial court granted a non-suit rendering judgment in favor of the defendants upon the theory that there was no showing which of the defendants were negligent, that the injury resulted from the act of any particular defendant or that the defendants had control of all of the instrumentalities which might have caused the injury.

The Supreme Court reversed this decision, holding that the familiar doctrine of *res ipsa loquitur* applied, the plaintiff thereby being relieved of the burden of proving how his injuries occurred or that they resulted from the negligence of any specific defendant.

The court stated that where the following three conditions were present, this doctrine requiring the defendants to explain the circumstances under which the injury occurred applies, that is, "'(1) the accident must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff."

The court stated that in a modern hospital the patient was quite likely to come under the care of a number of persons and that from the very nature of things a patient could not know all that occurred while he was under the effects of an anesthetic. Here an injury had resulted to plaintiff which had no connection with the surgical operation for which he entered the hospital. The court concluded:

"We merely hold that where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct."

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning Proposed Letter on California Sickness Insurance Laws. From an Over-seas Military Colleague:

Northern France,
7 February, 1945.

Members of Medical and Nursing Professions, *Addressed.*
Dear Sirs:

It has come to the attention of this organization, ————, an affiliated medical unit, now participating in a major way in the support of one of our armies on a portion of the battlefield of France, that the California Legislature is at present in the process of legislating a fundamental change in the practice of medicine. Our being so far away and legally and honor-bound to our Government on a mission so vital, not alone to ourselves over here, but to everyone of you at home, makes our position helpless in personally conveying to you our impressions on a subject so filled with possibilities, both good and bad. Therefore we substitute this letter, our only means of conveying our sentiments, and trust you will vouchsafe it a hearing with the full and fair appre-

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

ciation that only an imperfect minimal discussion is, by this means, possible.

It seems superfluous to historically sketch the progress of medicine and surgery during the wartime and peace-life of America; even the advances in the interval from World War I and II are phenomenal . . . the salvage of war's casualties in the present inferno statistically show that. America, today, leads the world in medical science and it has come about through a form of government that has "given the horse the bit" and permitted that free and unrestricted rugged individualism so inherent, and necessary, in the nurse and doctor.

In the hospital evacuation organization with which the writer is connected, are those who were born and reared in the time of, and associated with, the pioneer doctor and are thoroughly conversant with his period; there are a number who have experienced contract practice with both large and small organizations; others in the general practice of medicine; a number with a restricted specialty, and for two and a half years we have experienced governmental medicine. A cross section of the past experiences of our personnel gives a knowledge of the public and personal efficiency under the several systems, for no matter what the change might be, if made, it is interrelated to one or other of the above classification.

To qualify as a physician requires ten years of arduous and intensive work, with a cost of between $10,000.00 to $15,000.00. Not uncommonly, more generally than imagined, a goodly part or all of this is owing, when the young doctor begins his career; and ultimately, finally, if successful, he looks forward to a probable maximum, under the present contemplated medical legislative changes, of $5,000.00 per annum. Such a system, be it State or Federal medicine, is not a procreator of *good* medicine, for obvious reasons:

It becomes a political football where "whom you know" replaces "what you know"; wherein, comparable to the farmer situation, the middle man "eats" up the percentage and ever and anon the "have nots" are after the "haves"; where the incomprehensible human-behaviored people—the belligerent, the queer, the "jittery," the excitable, the depressed, the emotional and all the other variations of the non-pathologic and pathologic states (one of our deep problems here); where those with anything from minor head colds to corns; those of the age when a two weeks' rest in the hospital is preferable and more invigorating than travel, plus its cost, et cetera, et cetera, will clamor for and demand and receive hospital care. To provide for this type, and the *really* sick, will call for millions to be expended for added hospital facilities. It is not the high cost of medicine, rather it is the high cost of hospitalization . . . unfortunately both are added together.

In the last war, Prohibition, with all its divergent ills, was idealistically brought forward. Now comes State Medicine; Federal Medicine really, for there is no doubt California is being used as a guinea pig. What then? It is the entering wedge to sweeping social and economic changes of State and National scope.

Some months ago a questionnaire was sent to each medical man in the Armed Forces. This questionnaire made no mention of State Medicine but the question was asked: "Would you be interested in some form of group practice?" Group practice to a medical man means something entirely different from State Medicine but we are informed that on the basis of the answer to this question it is claimed that 53 per cent of the medical men in the Armed Forces are in favor of State Medicine. We feel this is a deliberate misrepresentation of the facts. This issue should stand or fall on its merits. The very fact that political trickery of this kind is used to put their proposition over is good evidence that political trickery would be used in its administration if it were adopted.

We in the army are a part of our American government . . . and yet we are not; by necessity we are restricted through Army Regulations—we must, and again we say, by necessity, work as a unit. Individualism and individualistic thinking cannot be, irrespective of what the general public might think. Does California contemplate a continuance of this creed? If so, rugged individualism is deader than Dante's Inferno. If this is to be true we suggest the magnificent, trite and ostentatious dictum: "Give me men to match my mountains" be effaced from our California state building, for it would be out of place.

No part of any subject under discussion is unilateral. Medicine has its ills, both organically and individually. We have our weak links . . . but so does every other chain; so long as human nature is human that will be true. We are accused of supporting a Medical Trust. Nothing is further from the truth; the very individualism of its membership prevents such, but we can readily understand how through legislative submersion it might readily be coined. There are many, many members not in accord with either our state or national organization; in like manner there are many many workmen within the crafts not in accord with their leadership . . . such is Democracy.

We have tried, are continuing to try (with some success we feel) and will keep on trying to give the sick, no matter what their station in life or whether their purse is full or empty, that same good care. If there are "gaps" in the care of our citizenry, and we are told there are, and if there are certain groups wherein the cost of medicine (again we feel it to be the cost of hospitalization and not of medicine) is a hardship, it would not appear difficult to adjust such weaknesses by collaboration, one with the other.

The doctor does more than his share of charitable work and through the ages has shown his humanitarian instincts. To revolutionize medicine, is not, seemingly, a sane and sensible approach.

But if our legislative forum feels socialization of medicine, in the manner it is proposed to them, is correct—that that approach is sane, sensible and the only access to the proper protection of the health of our people they have an obligation superior to any appeal we might produce. However, if the procedure is the correct one for the one profession, why should it not be true for all?; the purport to the basic principle is the same. If we can be convinced the point is well taken then we are duty, and morally, bound to make the program a general one.

We are, Sir, in anticipation,

Very truly yours,

(Signature of an Over-seas Colleague.)

San Francisco Hospital Policy

San Francisco's system of emergency hospitals will not be closed during this wartime period of a shortage in hospital beds, Chief Administrative Officer Thomas A. Brooks said recently.

He added further that he expects no recommendation to close them to come from two public health doctors now surveying the city's health department.

Dr. J. C. Geiger, city health director, said demands have been made upon him for an expansion of the emergency hospital system. Both the Richmond and Bayview districts seek such hospitals, he said.

The survey, expected to be completed in three weeks by Drs. Carl Buck and George Palmer, was undertaken to determine if the city is utilizing its public health facilities in the best manner. It was not intended as a criticism of Dr. Geiger, and is expected to praise his administration.—San Francisco *Examiner*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 3, March, 1920

EXCERPTS FROM EDITORIAL NOTES

State Society.—At the last meeting of the Council, held January 24th, 1920, among other matters of a routine nature, the forthcoming annual meeting of the Medical Society of the State of California was discussed at length. . . .

An Appreciation.—Years pass swiftly; fleeting events come and go. The problems of yesterday are forgot in the exigencies of today. With the passing of the problem, we are liable to forget the man behind it. . .

The Medical Society of the State of California (California Medical Association) has been built up by the hard labor of successive champions in the cause of better medicine. These men and women have had idealism; they have been activated by steadfast purpose and have spent their life's energy in our behalf. Where others were indifferent and neutral, these leaders forged ahead and bid us follow. They led the fight against disease, ignorance and vice. They wrought the machinery for preventive medicine. They educated and coerced the public into better sanitation and personal hygiene. They built up the laws and ordinances which make for higher medical standards and eliminate quackery. We reap the benefit of their pioneer industry. We saw them at work; possibly, we differed with them over methods and means of achievement; mayhap, we scoffed at their efforts. Nevertheless, we have been blessed by the fruits of their labor. They were vital; they did not spare themselves. But now the spark has gone and the flame grown dim. We see them pass. In passing let us doff our hats and do them homage.

You who have served—you have given what cannot be lost. For the good you have done, we now offer you our gratitude.

You are among the Immortals.

Nurses Needed.—"What are we going to do to get more nurses?" This question has been asked of the JOURNAL in written and various verbal forms so often, that we decided to place the question before all our readers instead of continuing to answer it privately and piecemeal.

That there is a shortage of trained nurses, and nurses in training, is generally felt. The medical profession is the first to feel this need and appreciate its seriousness, but it is a matter of concern to every hospital and to every citizen and family of every community. . . .

Botulism.—Botulism has been recorded more frequently in California probably because more constant search has been made for it, although possibly because its incidence may be higher on the Pacific Coast.

Not only is botulism a form of meat poisoning, but it has arisen from the use of home canned products, both vegetables and fruits, in various parts of the country. . . .

(Continued in Front Advertising Section, on Page 17)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

Dr. Richard O. Bullis of Los Angeles was appointed by Governor Warren, vice Karl C. Gummess, whose term expired on January 15, 1945. Dr. Frederick N. Scatena of Sacramento was reappointed by Governor Warren, his previous term having expired on January 15, 1945.

An oral examination will be held in the Board office, 515 Van Ness Ave., San Francisco, on May 20, 1945. The examinees at oral examinations comprise doctors from other states applying on licenses issued more than ten years ago. Also certain Army and Navy doctors are required to take the oral examination and certain other physicians must also pass this examination.

An additional written examination has been scheduled to be held at Native Sons Hall, 414 Mason St., San Francisco, May 21, 22 and 23, 1945. This examination was scheduled to accommodate many applicants located in the northern part of the State, who expect to enter military service on June 1st. Applications for this examination should be received at least two weeks prior thereto.

News

"In view of the urgent need for trained physical therapists and at the request of the War Department, the Children's Hospital Society and Clinic, located at 4614 Sunset Boulevard, announced today it would begin a six-months emergency course of study, beginning February 5. At the present time there is a great need for trained therapists in army, navy and civilian hospitals, Lily H. Graham, technical director of the hospital declared, adding that, to remedy this shortage, the course of study in therapy will be open to women only who have passed their thirty-seventh birthday and who are either registered nurses or have had at least 60 semester hours of college." (Los Angeles *Herald and Express*, January 2, 1945.)

(Press dispatch dated Sacramento, January 24, 1945.) "Backed by prominent Californians, a broad legislative program designed to give adequate education and medical treatment to an estimated 10,000 children in the State crippled by cerebral palsy was presented to the State Legislature today. Key features of several bills going into both houses of the Legislature are provisions to establish two hospital schools, one in Southern California and the other in Northern California. They would be operated by the University of California and the State Department of Education. It is estimated each school would cost $200,000 to build. The schools will provide both special education and medical treatment, including physiotherapy, for spastic children who have been afflicted with cerebral palsy usually caused by injuries at birth . . ." (Los Angeles *Examiner*, January 25, 1945.)

" 'Plasma and more doctors—they are what the navy needs to carry on the Jap war in the South Pacific.' That was the declaration made today by Lieut. Comdr. Edwin S. Budge, Jr., Los Angeles ear, nose and throat specialist,

(Continued in Back Advertising Section, on Page 34)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



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Metamucil softens the fecal residue, protects intestinal mucosa and exerts a gentle, stimulating, physiologic peristalsis.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 30)

many a scintillating remark possibly expressed in humor left food for serious thought for many a day. All expressed the meeting of definite cultural value and hoped it might be repeated at least once a year. . . .

From an Article on "Perforated Gastric and Duodenal Ulcer," by Harlan Shoemaker, M.D., Los Angeles.—Perforated duodenal or gastric ulcer in a hospital population of 1,000 and a civilian population of 1,000,000, under the law of averages amounts to about 10 cases a year. Its onset is generally accompanied by sudden agonizing pain in the abdomen, with extreme rigidity of the abdominal wall, vomiting and tympanitis. If left unoperated, a period of easement follows the onset, only to be superseded by a recurrence of pain, followed by peritonitis and death. In the Los Angeles County Hospital, 22 cases of perforated gastric or duodenal ulcer occurred from 1916 to 1918, inclusive. Six of these patients died. These 22 cases were divided among nine operators. . . .

Excerpt from Los Angeles County Medical Meeting, Nov. 6, 1919, Friday Morning Club Hall: Hospitals. New Superintendent for County Hospital.—Norman R. Martin, Superintendent of Charities, announces the appointment of D. Neal Naramore Wood, as First Assistant Superintendent of Charities and Medical Director for the Department of Charities of the County of Los Angeles, effective November 1, 1919.

Excerpt from Hospital Service Department: The Hospital Betterment Movement in California.—The Great War focused public interest upon hospitals, and one of the most important post-war reactions upon civil life is the enormous increase in hospitalization of the sick. With this reaction there has developed not only a keen interest in hospitals, but an intelligent and earnest desire to know more about hospitals and their methods of operation. Even the intelligent layman no longer looks upon the hospital as a hotel for the sick, and the time is not far distant when institutions of this class will find it desirable to enter a broader and more useful field of community service. . . .

Excerpt from State Board of Medical Examiners.—The tax for any year is payable prior to January 1st of each year.

The tax is payable for the right to practice for any portion of the year and is not payable upon the installment plan.

Upon March 2nd (leap year, March 1st) the tax becomes delinquent, the name is eliminated from the directory and the possessor of such license loses the right to practice in California.

The license will be restored upon the payment of a registration fee of $10. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page, 152)

on the basis of his two years' service in the South Pacific area. . . . Wounded on Peleliu on the second day of the invasion—Sept. 18—Commander Budge exhibited a fragment from a Jap mortar removed from his neck by a Pasadena doctor friend, Comdr. William Delphy, who happened to be stationed on a nearby hospital ship. . . ." (Los Angeles *Herald and Express*, January 2, 1945.)

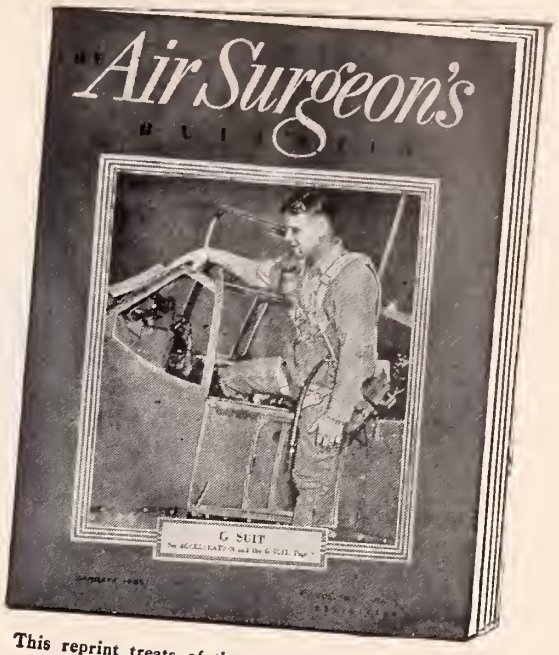
(Continued on Page 40)

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Solution of the blackout problem involved physiological research of marked interest to the medical profession. With the permission of the Army Air Force Medical Services, we are offering to the medical profession a reprint from *The Air Surgeon's Bulletin* of January, 1945.

* In the development of the combat unit we had the cooperation of the following:

The Aero-Medical Laboratory, and the Proving Ground Command of the Army Air Forces; the Medical Research Section of the Bureau of Aeronautics of the United States Navy; the National Research Council's Committee on Acceleration, members of which are associated with the Mayo Clinic, Johns Hopkins, Banting Institute, Yale University—and other medical and aviation authorities.

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*Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245.
**Laryngoscope, 1935, XLV, No. 2, 149-154.

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Vitamin B_1.....666 U.S.P. Units
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Vitamin G (B_2).....2 milligrams
Vitamin B_6.....50 micrograms
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Liver Subs. Cono. (1:50) (1 Gm. derived from 50 Gms. fresh liver)	0.20 gm.
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A child's second birthday does not confer a magical protection against rickets, as has well been demonstrated by a recent study[1] at Johns Hopkins Hospital in which almost fifty per cent of the children between the ages of 2 and 14, who died from various causes, were shown to have evidence of rickets.

Protection "as long as growth persists" can be readily achieved with dependable, potent, Upjohn vitamin preparations, available in forms that meet the varying needs of infancy, childhood, and early adolescence.

1. Am. J. Dis. Child. 66:1 (July) 1943.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

"The *Journal* of the American Medical Association complains that 'on a nationwide basis school health service is probably the spottiest and least effective branch of standard recognized public health procedure.' In many instances, the *Journal* says, health examinations given students are wholly inadequate, and it adds that insufficient attention is devoted to such problems in school buildings as fresh air, light, heat, overheating, sanitation and careful medical examination of students returned to school following periods of illness." (Editorial, San Francisco *Call-Bulletin,* January 9, 1945.)

"Civilians who have never seen a battle cannot realize what battle wounds are like. It is well for us that we cannot. But since most of us are emotionally linked with young men who are or may be in battle, it is also well for us to know something as to what is being done to minimize battlefront horrors, to relieve pain, to save life. In the army this is the work of the medical department. The soldiers and officers of this service wear the Geneva Cross, which is also the insigne of the American Red Cross society. Coöperation with the Red Cross, which has given outstanding aid to the armed services, is close, but it does not and cannot extend into battle areas. In those areas, and in the field hospitals, evacuation hospitals, and base hospitals, the care of the wounded and the sick is wholly entrusted to the army doctor, the army nurse, and the army medical department enlisted man, not to the Red Cross. Those devoted noncombatants, some of them in every battle taking every risk run by the fighting troops, have cut the death rate for wounded

(Continued on Page 46)

CAMP Belt for Inguinal Hernia



Belt with pad in place

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(Patented)



Belt fitted, adapted to all types of build

IN patients with indirect inguinal hernia of small or moderate size, this belt with pad has proved successful in many instances in holding the hernia within the abdominal cavity. The comfort of a *belt* about the pelvic girdle is greatly appreciated by the patient.

The CAMP adjustable spring pad for use with the belt is equipped with prongs of piano wire. The strong flexible prongs fit firmly in the casings of the belt. Pads are available in varying shapes and depths.

The CAMP adjustment of the belt courses along the groin over the pad, hugging it in and up for the protection of the internal ring.

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The rooster's legs are straight.

The boy's are not.

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(Continued from Page 40)

men from World War I's eight in a hundred to three in a hundred. They have cut crippling bone infections from compound fractures from 75 per cent to 5 per cent. They have cut the death rate from disease to one-twentieth of its World War I level . . ." (San Mateo *Times and Leader,* November 10, 1944.)

"Officers of the State Board of Medical Examiners, the State Osteopathic Board and Police Lieutenant R. B. McCreadie yesterday raided the office of Dr. Mae A. Wilson, and arrested her on suspicion of performing an illegal operation. Marlene Forgus, 20, of 1219 West Sixth Street, who said she had just undergone an illegal operation at the office, 619 Black Building, 357 South Hill Street, was removed to Georgia Street Hospital in a critical condition. Miss Forgus gave the officers a detailed statement, in which McCreadie said she told them she paid Dr. Wilson $200 before the operation was performed". . . (Los Angeles *Examiner,* November 5, 1944.)

"Comdr. Wilson P. Goddard, formerly of 407 Monte Vista Avenue, Mill Valley, has been cited by Adm. W. F. Halsey for heroism in continuing his work as a medical officer despite dive bombing attacks on his transport ship" (San Francisco *Examiner,* November 15, 1944.)

"The first arrest, involving one of five women in the county suspected of practicing the profession of midwife without state license and the qualifications required by law, was reported this week after Joseph W. Williams of the Board of Medical Examiners in San Francisco and local officials took Mrs. Mattie Perkett, 45, of Route 1, Box 123, Visalia, into custody. She is a cannery worker. By her own admission, according to Williams, Mrs. Perkett has delivered around 100 babies in the Farmersville, Exeter and Visalia area in the past three years. . . . Williams indicated that while the reports of unlicensed midwives operating in Tulare county had been prevalent for some time, attention was focused here of late when an Exeter doctor reported that three mothers whom he had been treating had taken their cases to a 'professional midwife.' Williams interviewed nearly 15 of the more recent clients of Mrs. Perkett, he said, and all appeared surprised that she was not a qualified professional. . . ." (Exeter *Sun,* Sept. 7, 1944.)

San Francisco Health Survey May "Abolish" City Hospitals

Drs. Carl Buck and George Palmer of the American Public Health Association today were reported to be completing the report of their survey of the Health Department authorized by the Board of Supervisors on the recommendation of Chief Admr. Officer Brooks.

The report may recommend such drastic changes for efficiency as abolition of the five emergency hospitals, greater delegation of authority by Health Director

(Continued on Page 47)



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SAN FRANCISCO HEALTH SURVEY MAY "ABOLISH" CITY HOSPITALS

(Continued from Page 46)

Geiger to his assistants and more general admission of physicians and surgeons to practice at the County Hospital.

It was assumed the proposal would be to take emergency patients direct to the private hospitals. Much of the medicine at the County Hospital now is practiced under the supervision of the Stanford and California Universities' medical schools.

Dr. Geiger today said he could make no comment on the reported contents of the survey until he had read it, but added this was the first time he had ever encountered anywhere a proposal to abolish the city's emergency hospitals.

"There have been many suggestions that the service be increased," he said. "I recall that the Richmond and Bayview Districts were proposed for new emergency hospitals in the past."

San Francisco's set-up is unique, he said—not another community in the United States has anything to compare with it. To abolish it might save money, he added, "but it would not save lives."—San Francisco *News*, January 27.

What's Your Doctor Worth?

When the average family tallies up its doctor's bills at the end of the year, the result is apt to look like the national debt, casting a gloomy shadow over future earnings and offering circumstantial evidence that the medical profession must be a gold mine.

Actually, the national figures prove otherwise. The average income of doctors—counting high priced spe-

(Continued on Page 48)

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WHAT'S YOUR DOCTOR WORTH?

(Continued from Page 47)

cialists as well as country practitioners—is about that of a journeyman welder on the swing shift.

The doctor himself, according to Dr. Ray Lyman Wilbur, former president of Stanford University, gets about 30 per cent of the medical dollar; 70 per cent goes to the hospital, the nurses, the drug store, the dentist, the utilities and the owner of the hospital building.

"What the American people want is good medical care, and to have it handy," declares Dr. Wilbur. "Health is uneven, and distribution of care is difficult. But it must be done. We have got to find a better method of distributing medical care. The insurance principle must be applied to the problem. And physicians, not politicians, must be in charge."

When a loved one is ill and in desperate need of medical care, the doctor is likely to be considered worth whatever he costs at the time—however difficult it may be when the bill comes in.

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To earn the conscientious backing of the medical profession, any program for better distribution of public health facilities must be removed from politics by public demand. And to be worth to the average family whatever its cost may be, it must be kept out of politics in the same way.

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Army Treatment of Gonorrhea and Syphilis Told By General Morgan

In September, 1944, the penicillin supply problem had eased to the point where the Army made penicillin the drug of choice in the treatment of gonorrhea and limited the use of the sulfonamides to cases which did not respond to adequate penicillin therapy or where penicillin was not available through normal supply channels.

Outlining the treatment to the Military Surgeons, Brigadier General Hugh J. Morgan, U.S.A., Chief Consultant in Medicine to the Surgeon General, said that "the initial treatment schedule recommended is 20,000 units intramuscularly every three hours for a total dosage of 100,000 units. Patients in whom a favorable response is not obtained by the third day are re-treated with 100,000 units. When patients fail to respond to the second course, a third course of penicillin totaling not less than 300,000 units, administered in 20,000 unit doses every three hours is recommended. Should this fail, sulfathiazole or sulfadiazine is used, employing a dosage of 4 grams initially, followed by 1 gram every four hours day and night for five days."

"It is too early, of course," said General Morgan, "to evaluate the effect of this new policy regarding the treatment of gonorrhea. There is every reason to believe that we shall look upon it in restrospect as constituting one of the most conspicuous advances made during this war in military medicine, in light of its almost certain favorable effect upon morbidity and noneffectiveness, and this in spite of a rising incidence rate."

In October, 1944, the penicillin treatment of syphilis was authorized throughout the Army. "The total dosage

(Continued on Page 56)



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1. Hawaii Medical Journal, Vol. 3, No. 5, pp. 222-226, May-June 1944.



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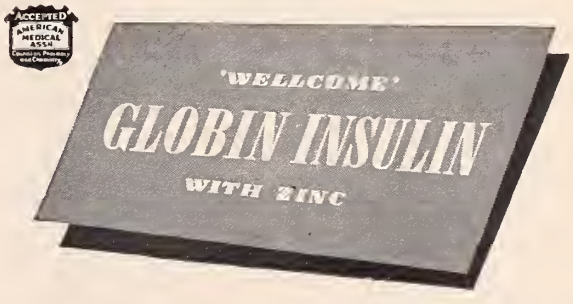
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ARMY TREATMENT OF GONORRHEA AND SYPHILLIS TOLD BY GENERAL MORGAN

(Continued from Page 52)

for early syphilis and latent syphilis," said General Morgan, "is 2,400,000 units given in sixty consecutive intramuscular injections of 40,000 units at three hour intervals day and night for seven and one-half days. No additional anti-syphilitic therapy is to be given during or after the completion of the course of penicillin, except in the case of penicillin treatment failures. Prior to October 11, 1944, this method of treatment had been authorized for overseas theaters. Since that date it applies also to the zone of interior. Within the limits imposed by this short period of study, we have reason to believe that this method of treating syphilis will be every bit as effective and much less dangerous than any treatment plan heretofore employed."

Army Malaria Control Threefold Problem Says General Simmons

The Army has made great progress in the control of its No. 1 disease hazard, malaria, according to Brigadier General James S. Simmons, U.S.A., Chief of the Preventive Medicine Service, who described Army methods of malaria control to the Military Surgeons meeting in New York City this month. In the Army, the problem has two aspects, General Simmons said—control in base areas and protection of troops in combat. The first is primarily mosquito control, and specialty trained personnel are required to produce effective results. The malaria control organization in the Army Medical Department includes medical officers trained in malariology, and small survey and control units headed by parasitologists, entomologists and sanitary engineers.

The second aspect—protection of troops in forward

(Continued on Page 58)



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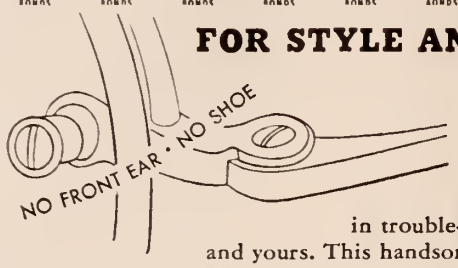
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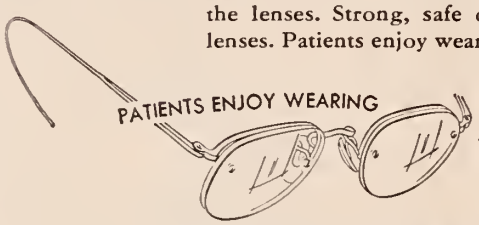
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ARMY MALARIA CONTROL THREE-FOLD PROBLEM, SAYS GENERAL SIMMONS

(Continued from Page 56)

and combat areas—depends upon individual measures of protection in addition to mosquito control, according to General Simmons, and strict malaria discipline must be established and enforced. Soldiers must be drilled in the use of repellents, sleeping nets, protective clothing and insecticide sprays in the same way they are trained to use combat weapons.

Concerning the third aspect—the possible spread of malaria in this country by returning soldiers—General Simmons said that members of the armed forces who have had malaria will be given sufficient treatment to render them free from demonstrable parasites before they are discharged. In addition, men who have had malaria or served in malarial regions are advised to seek prompt medical attention and have a blood smear for malarial parasites in case of illness with fever.

However, he added, prevention of malaria in this country, as elsewhere, depends essentially upon the control of the malaria carrying mosquito.

Erb's Paralysis.—Other than a description of the brachial palsy which bears his name, Wilhelm Erb made many valuable contibutions to the science of medicine. He introduced galvanic and induction currents as diagnostic aids, and later followed Duchenne in the extensive development of electrotherapy. He wrote important handbooks on the diseases of the cerebrospinal nerves, as well as of the spinal cord and medulla. The modern theory of muscular dystrophies was advanced by his studies.—Warner's *Calendar of Medical History.*

Most men employ the earlier part of life to make the other part miserable.

—La Bruyère, *Les Caractères*, Sec. 11.

recent extensive investigation confirms contraceptive effectiveness of the active ingredient in Koromex Jelly

A most illuminating report based on extensive clinical and experimental data has recently been published by Eastman and Scott (Human Fertility, 9:33, (June) 1944.) These authors studied the safety and efficacy of phenylmercuric acetate which is the active constituent of Koromex Jelly.

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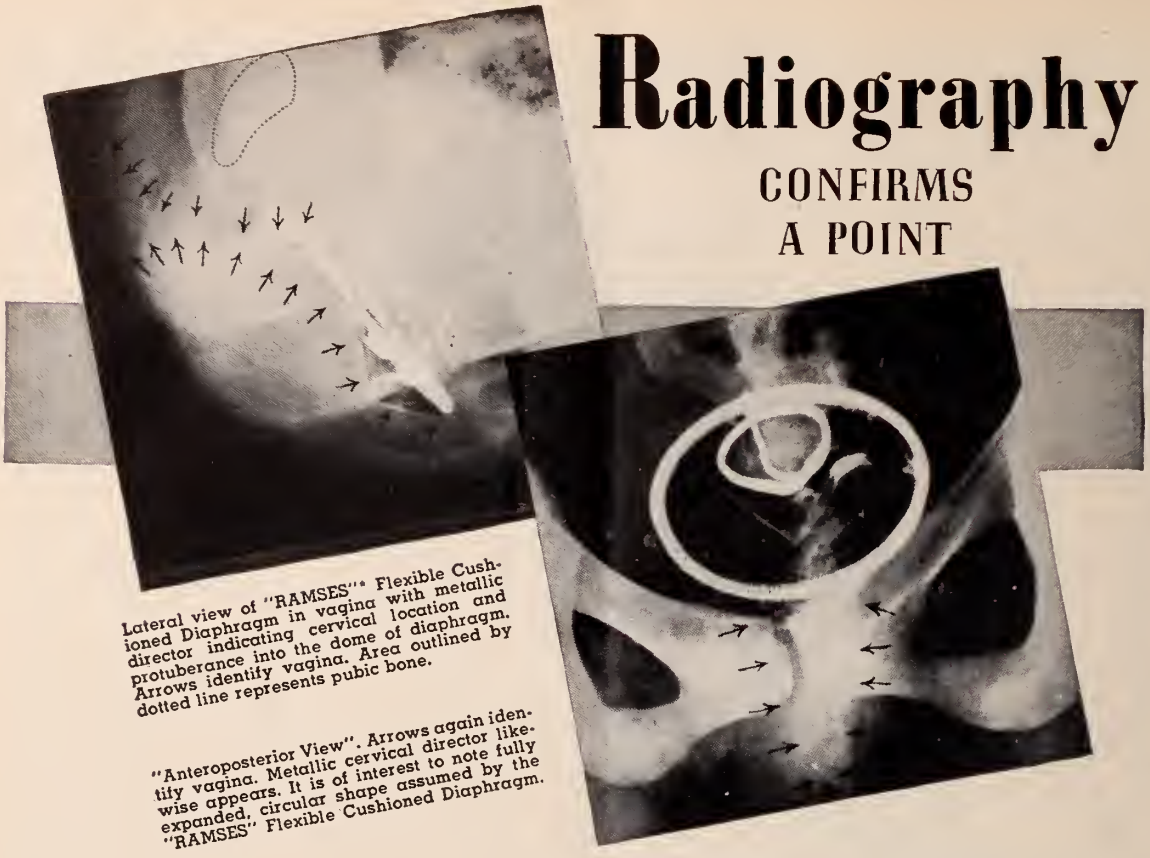
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Miscellaneous California Medical Organizations

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San Francisco—1122 Phelan Building, 760 Market Street, San Francisco, 2; UNderhill 8700.
Sacramento—631 J Street.
Los Angeles—State Office Building, 217 West First Street, MAdison 1231.
Director, Wilton L. Halverson, 603 Phelan Building, 760 Market Street, San Francisco, 2.

California Northern District Medical Society

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Board of Medical Examiners of the State of California

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Los Angeles—906 State Building.
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Southern California Medical Association

President, Reginald H. Smart, 1136 West Sixth Street, Los Angeles.
Secretary, Nelson P. Anderson, 2007 Wilshire Boulevard, Los Angeles.

Medical Society of State of California

Optional Medical Defense—C. M. A. Members. Room 2008, Four Fifty Sutter, San Francisco, 8.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco (8) office, 251 Kearny Street, phone SUtter 3470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

Medical Schools of California

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California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

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Tropical Medicine. By Sir Leonard Rogers, K.C.S.I., C.I.E., LL.D., M.D., B.S., F.R.C.P., F.R.C.S., F.R.S. Major-General, Indian Medical Service, Ret.; late Medical Adviser to the India Office, and Physician and Lecturer, London School of Tropical Medicine. Lecturer on Tropical Medicine, London School of Medicine for Women; late Professor of Pathology, Medical College, Calcutta, and Sir John W. D. Megaw, K.C.I.E., B.A., M.B., Hon. D.Sc. (Queen's University, Belfast), Major-General, Indian Medical Service, Ret.; late Medical Adviser, India Office and Lecturer, London School of Tropical Medicine; formerly Director-General Indian Medical Service; formerly Director and Professor of Tropical Medicine, Calcutta School of Tropical Medicine and Hygiene. Fifth Edition. Cloth. Pp. 518, with 2 Colored Plates and 87 Text-figures, Baltimore: The Williams and Wilkins Company, 1944.

My Second Life. By Thomas Hall Shastid, A.M., M.D., LL.B., Sc.D., F.A.C.S., F.A.C.P., etc. Cloth. Pp. 1174, illustrated. Ann Arbor, Michigan: George Wahr, Publisher to the University of Michigan, 1944.

Clinical Roentgenology of the Digestive Tract. By Maurice Feldman, M.D., Assistant Professor of Gastroenterology, Mercy Hospital, Consulting Roentgenologist, Sinai Hospital. Cloth. Price, $7.00. Second Edition. Baltimore: The Williams and Wilkins Company, 1945.

BOOK REVIEWS

Anatomy As a Basis For Medical and Dental Practice. 863 pages. By Donald Mainland, M.B., D.Sc., F.R.S.C. Professor of Anatomy, Dalhousie, Halifax, Nova Scotia, Canada. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers.

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(Continued from Page 7)

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(Continued on Page 20)



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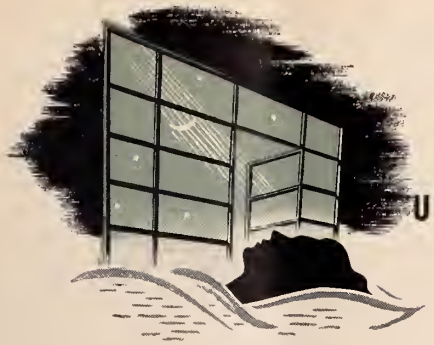
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ROBERTS, H. K. et al.
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MAGNESIA	339.3 parts per million
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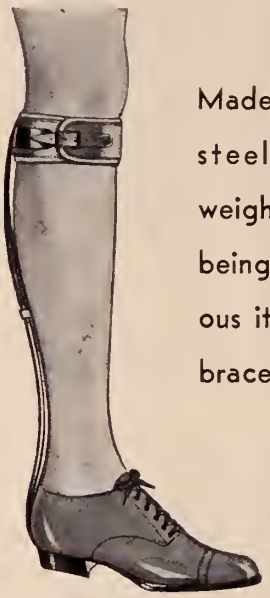
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(Continued from Page 10)

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 240)

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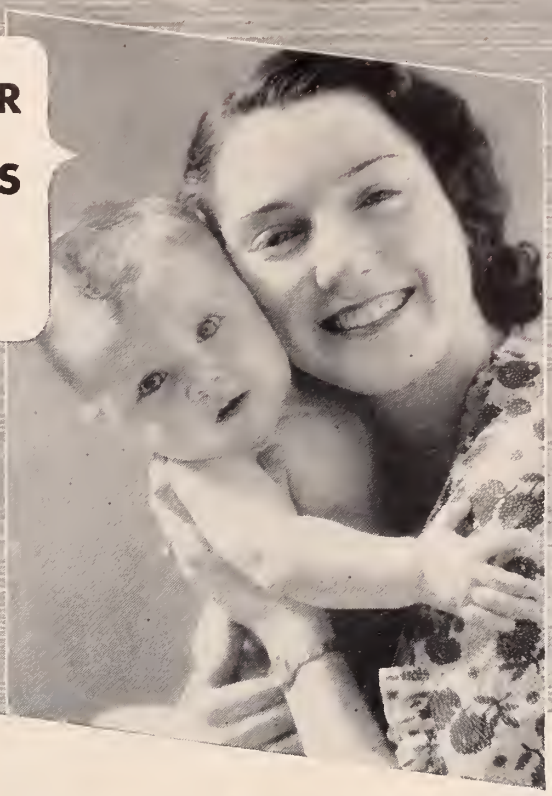
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(Continued on Page 28)

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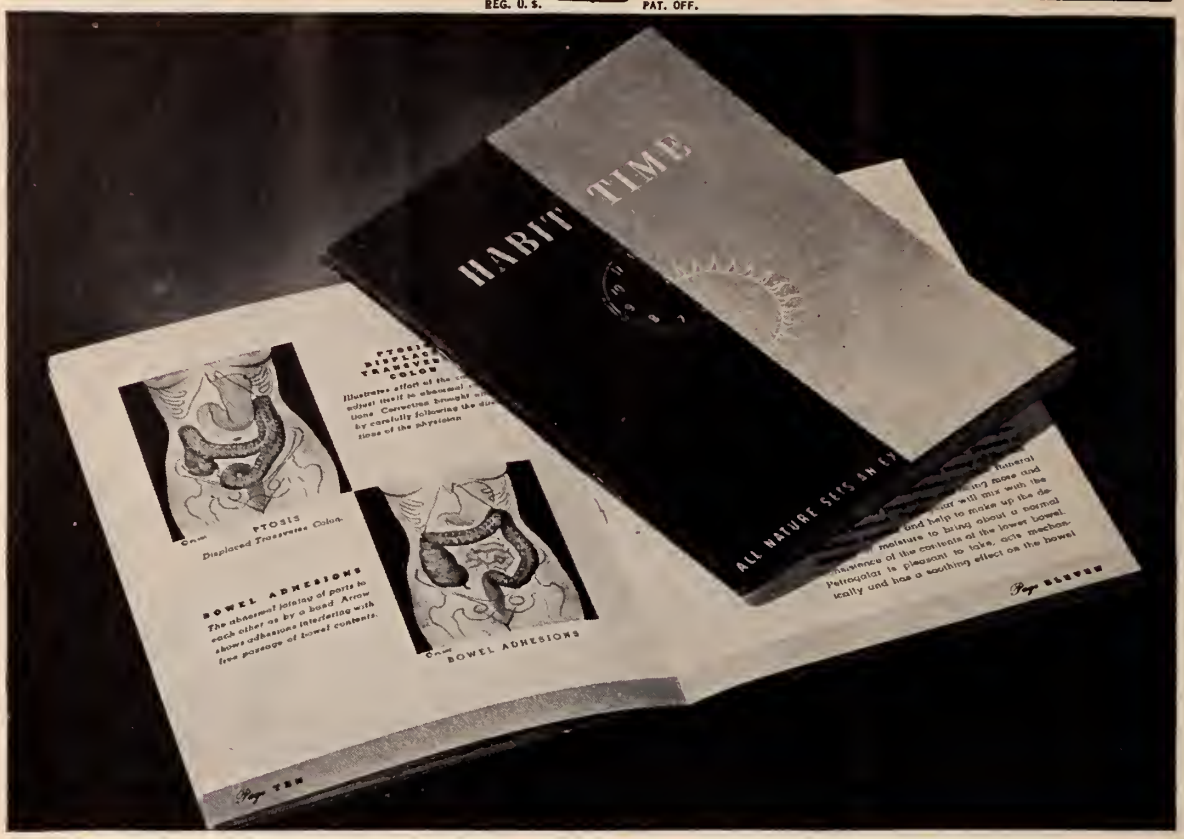
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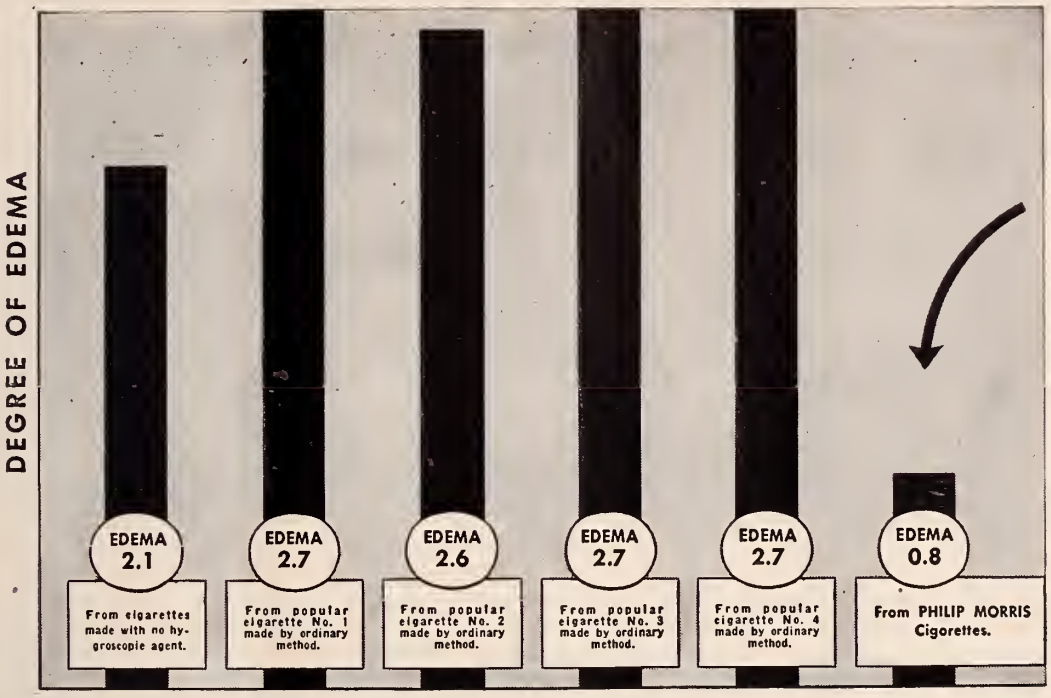
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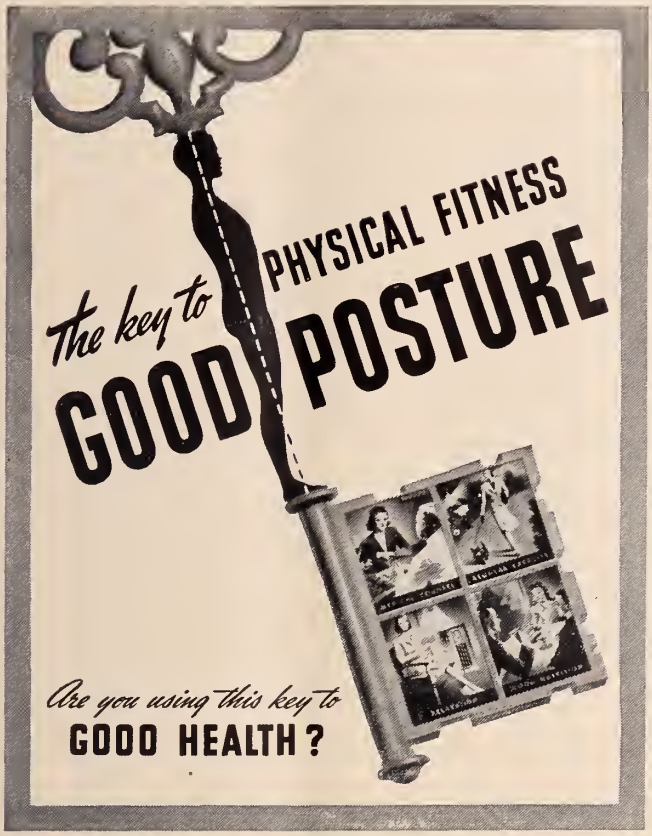
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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

Vanderburgh, of the California State Osteopathic Association, stated in unequivocal terms to the writer, that osteopathy includes the giving of drugs, and the use of surgery. Doubtless, some sweet day osteopathy will celebrate its adolescence by becoming indistinguishable in education, content and method, from modern scientific medicine. China has many times been conquered. Each time she has benevolently assimilated and thoroughly digested her conquerors, and pursued her way unperturbed. Osteopathy may give rise to some transient indigestion but such rapid growth as recorded above, can but end as did the Lady and the Tiger.

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From an Article on "Review of 1918 Census of Causes of Death."—The Census Bureau's annual compilation of mortality statistics for the death registration area in continental United States, which will be issued shortly, shows 1,471,367 deaths as having occurred in 1918, representing a rate of 18.0 per 1,000 population, the highest rate on record in the Census Bureau—due to the influenza pandemic.

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(Continued on Page 36)

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 62 APRIL, 1945 NO. 4

California and Western Medicine

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

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George W. Walker (Chairman)	Fresno	1946
F. Burton Jones	Vallejo	1947
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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

IV. PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Continued)

Present Status of the Proposed Sickness Insurance Legislation for California.—At the time of this writing the legislative battle concerning Governor Warren's Health insurance bill (A.B. 800) and the C.I.O. measure (A.B. 449) is being vigorously carried on before the Assembly Committee on Public Health.

In previous issues of CALIFORNIA AND WESTERN MEDICINE, brief press reports were given concerning preliminary Committee hearings already held in San Diego, Los Angeles, Fresno and San Francisco.

A largely attended meeting was held on Tuesday afternoon and evening, March 24th, when, in the Assembly Chamber at Sacramento, the Committee on Public Health held an open session for discussions on the basic purposes and provisions of compulsory sickness insurance systems. The Committee allocated time to both proponents and opponents.

The major speaker for the proponents was Nathan Sinai, professor of public health in the University of Michigan, who had come to California, the press stated, on invitation from Governor Warren's office. Professor Sinai is a Californian by birth (Stockton). He received his degree of Doctor of Veterinary Medicine from San Francisco College in 1915, and his Doctor Public Health diploma from the University of Michigan in 1926. Because of his writings on the subject of sickness and health insurance, the views of Doctor Sinai are fairly well known. However, in his initial appearance at Sacramento, report states, he did not fare so well. The California Legislators partake of the spirit of the "Forty-Niners." They do not beat about the bush, and they went after Professor Sinai without gloves.

The other principal advocate for a compulsory health insurance system was Professor Samuel Chester May of our own University of California, who has been the director of its Bureau of Public Administration since 1930; and whose numerous discussions of the topic, before the Commonwealth and other clubs, have likewise acquainted many Californians concerning his opin-

ions. In passing, it may be said that Professor May is reputed to have had considerable to do, directly or indirectly, with the outlining or drafting of some of the inclusions in Governor Warren's bill (A.B. 800). The writer does not know whether this is, or is not the fact.

The Assembly Committee on Public Health will hold additional hearings, one on April 3. In due course a report, with or without recommendations, will be submitted to the Assembly. What action and how soon, the State Assembly and later the State Senate will take on the sickness insurance measures that have been presented, is not possible to forecast at this time. The old story of what a jury or a legislature may or may not do, can be said to apply.

Elsewhere in this issue paragraphs appear from which more information may be gleaned concerning the controversial discussions going on between the opposing groups. In CALIFORNIA AND WESTERN MEDICINE, an effort has been made to present informative items on the contentions of both sides. It is important that physicians understand the nature of the claims made by opponents. The arguments of both groups should be read.

* * *

Regrettable Mental Outlook of Many Proponents of Compulsory Sickness Insurance Plans.—It is unfortunate that in their pronouncements, the proponents of compulsory sickness insurance plans so often give evidence of confused thinking. Many of this group of advocates seem unable to appreciate that their theoretical, blue-print solutions of the problems related to serious illness among citizens of the lower wage earning groups should not be applied to the elimination of disease, but rather to the economic conditions or poverty with which disease is so often associated. If some of these self-appointed or self-anointed altruists would concentrate their efforts on the basic causes of poverty, they could be of greater service to the lower income groups whom they state they wish to serve. Concerning the causation and the treatment of disease, physicians are well qualified to carry on, by virtue of greater education, training and experience. Doctors of Medicine wish only the right to maintain and develop the standards of procedures through which disease can be best overcome, and they can and will do this, if the blue-print reformers keep their hands off the system of American medical practice, through which excellent public health successes have been attained.

Physicians agree that a better distribution of the facilities of modern day scientific medicine, whereby the same would be available to all groups of citizens, is desirable.

Nevertheless, let it be remembered, that for many years past, during which the lay public and government vouchsafed only scant attention to the medical needs of men, women and children in the lower economic or income groups, it has been the Doctors of Medicine, who individually and collectively, have given increasing care to these classes of fellow citizens. And today, as in years past, the same generous professional care is being granted to all fellow citizens,—whether indigent, medically indigent, moderately or very well-to-do.

This healing-art service has been rendered under the existing system of free enterprise in medical practice,—a plan which gives opportunities for alert thinking and initiative, with corresponding pleasure and heart-satisfaction that comes with service well-rendered.

However, free enterprise in medical practice and its excellent results would go into more or less decay under any plan of a regimented profession, since then there would rapidly develop a political control dominated by bureaucratic supervisors, under whose supervision scientific medicine and healing-art practice could not hope to prosper.

Naturally, the proponents of the so-called compulsory health systems deny this. That is not surprising, since persons who sometimes have little knowledge of the elements and scope of certain problems, are at times only the more dogmatic concerning the establishment of their personal plans of solution.

* * *

Money Value of Medical Services Rendered by Physicians in County Hospitals of California.—Through all the years, since California was admitted to the Union, Doctors of Medicine have given generous professional care to patients in the public county hospitals of California. At the same time, in the lay press, minor donations by lay persons, of one or a few thousands of dollars, and designed to promote the public weal, often have received newspaper and other praise without special regard to space or real value.

Taking for example, by contrast, the massive Los Angeles County Hospital, an institution having a probable 20 million dollar capital investment in buildings, with an annual maintenance budget of many hundreds of thousands of dollars, there has yet to appear, for the first time, in a printed report of that institution, anything like a detailed statement of the money value of the professional services annually rendered without cost to patients or taxpayers, by some five hundred or more physicians who are on the attending staff of that institution, and who give gratuitous service.

Why should the public be expected to be grateful if it has never been informed concerning such massive donations in service, gladly given by attending staffs of this and other county hospitals in California?

* * *

Application of Gratuitous Professional Service to Pending Legislation.—The above digressions to some readers, may appear somewhat of a far cry from pertinent comment on the health insurance bills now pending in the California Legislature. However, they are not.

For, from this record of faithful medical serv-

ice rendered by physicians over many years to citizens in the lower wage groups, it would be a logical conclusion to infer that Doctors of Medicine, trained as they have been, concerning the prevention and treatment of disease and injury, are as much and even more anxious than any group of lay propagandists, to *provide the best of medical care for all classes of citizens.*

Many of the lay shouters for reform in medical practice and procedures close their eyes to these patent facts. They, in their self-sufficient ego, and with little or no technical background on which to base their contentions, have nevertheless worked out comprehensive paper plans for radical changes and so-called reforms in medical service in California and elsewhere, and are insisting such be immediately enacted into law.

It is depressing to think that these misguided individuals and propagandists, through their continued campaigns, should have been able to mislead so many honest citizens into accepting their specious schemes.

* * *

Physicians Must Be Alert to Proposals to Change Medical Practice through Legislation.—Which fact emphasizes again the reason why every physician must remain alert concerning medical economic problems, the procedure-solutions of which would change the nature of medical practice. Every Doctor of Medicine should likewise become somewhat of a propagandist concerning medical needs, he giving to patients and friends alike, authoritative factual information concerning modern-day American Medicine and its practice. If every physician had done this, some of the present vexatious problems would not have arisen.

California has no environmental factors among low income citizens such as existed in Germany when in 1881, Bismarck initiated his Krankenkassen system in order to combat socialistic trends, or when, in 1911, Lloyd George, in like manner, brought into being the English panel system of medical practice.

American Medicine in those days and since, has given good professional care to fellow citizens who, at the same time, were enduring hardships from economic causes.

In California the medical profession asks that no system of regimentation be established that will lead to a lower grade of medical practice and service than now exists.

Whatever deficiencies in distribution of medical care may exist in our State can be remedied through thoughtful study, whereby, through progressive and evolutionary improvements, any inadequacies may be eliminated.

Revolutionary procedures are not indicated, and such, in essence may be found in A.B. 800 (Governor Warren's bill) and A.B. 449 (C.I.O. bill), now pending before the 56th California Legislature.

Those bills must not pass.

C.M.A.'S 74TH ANNUAL SESSION—LOS ANGELES, SUNDAY-MONDAY, MAY 6-7, 1945

This Year's Annual Session More Streamlined Than Ever.—Owing to wartime conditions, and with special reference to rules laid down by the Federal Office of Defense Transportation, this year's annual session of the California Medical Association will be more skeletonized and streamlined than ever. There is no alternative. To conform with the rules laid down by the Office of Defense Transportation it has been necessary to limit to less than fifty the number of C.M.A. members who travel by rail to Los Angeles, where this year's session will be held on Sunday-Monday, May 6-7, 1945. The C.M.A. headquarters office is holding down transportation requests to less than that number in order to conform to the Washington directive. The sanctions to travel will be limited to members of the House of Delegates; since the business of the organization must be carried on, not only to safeguard the 5,000 members who are in civilian practice and working overtime in essential and other industries, but also to properly protect the rights of the more than 2,000 California colleagues who are in military service.

* * *

Public Health Interests Indicate a Business Session.—In this present year, the 56th California Legislature is in session and important legislation is pending that would establish in California, in case one or other of the compulsory sickness insurance bills was enacted, a system of practice under which scientific medicine would receive a serious setback, and the health of workers in essential industries be endangered.

* * *

Meetings of the Scientific Sections Will be of a Local Nature and Under the Sponsorship of the Los Angeles County Medical Association.—In the OFFICIAL JOURNAL for February on page 97, and in the March number on pages 106 and 137, brief statements appeared concerning the scope and nature of the Scientific Sections and the places where the programs would be given.

In order to avoid use of hotels, all meetings will be held in the Elks Temple and in the headquarters building of the Los Angeles County Medical Association. The California Medical Association has thirteen scientific sections, and this year, because of these changed conditions, it will be necessary for the first time to have a number of sections give programs on Sunday afternoon and Monday morning, as well as on Monday afternoon. It is gratifying, in spite of all existing handicaps, to be able to state it has been possible for the C.M.A. Committee on Scientific Work and the officers of the respective sections to secure a total of 100 papers. All papers listed on the program will be available for publication-consideration in CALIFORNIA AND WESTERN MEDICINE. Acknowledgment for some of this success must be made to the Committee on War-

time Graduate Medical Meetings for the 24th Zone (Southern California) of which Lt. Comdr. George C. Griffith of Corona is Chairman. The programs will list a large number of military colleagues who are attached to hospital stations in Southern California. Many of these speakers, in civilian practice, were on medical school and hospital staffs, and their willingness to present papers is another indication of the good will that exists between physicians in civilian and military life.

No scientific or commercial exhibits will be given this year. However, it is hoped to be able to present on Sunday evening of May 6th, in the Lodge Room of the Elks Temple, a series of restricted films put out by the Army. These are of much interest and should merit a large attendance.

* * *

Suggested Procedure for House of Delegates. —Concerning the make-up of the House of Delegates, in relation to members of the Association who have been elected as delegates or alternates, or who will be otherwise qualified to act as delegates, it is proper to state that every duly elected delegate or other member who in due form is seated as a delegate, will have the right of the floor in the House to make motions, present resolutions or to speak on motions.

It has been suggested, however, because of the limited number of non-resident delegates who will be able to go to Los Angeles to act as members of the House of Delegates, there be an agreement in regard to voting. Thus, on questions of division necessitating a count of votes, it may be possible for delegations of the component county societies to agree that, instead of one vote for every fifty members of the Association, as provided in the Constitution, there be one voting spokesman for several delegates, say in the proportion of one voting spokesman for some 200 members. The Speaker of the House of Delegates will present this entire matter to the House when it convenes. The item is mentioned here to explain why such a change in procedure has been suggested.

* * *

Programs Will Appear in the Bulletin of the Los Angeles County Medical Association. —For reasons noted above, the publicity concerning the annual session, which heretofore has always been a prominent feature of the April issue of California and Western Medicine, will not be given. However, a box schedule of the places and hours of the meetings appears in this issue, on page 187.

Through the courtesy of the Los Angeles County Medical Association, the full scientific program will appear in *The Bulletin* of that large county unit which, as stated on page 106 of the March issue, is exceeded in number of members by only ten of the constituent State Associations of the A.M.A. With such a large local membership, the attendance at the meetings of the Scientific Sections should be excellent, and it is hoped that all members of the Los Angeles County Medical Association will arrange their schedules to permit them to participate in these meetings to fullest possible extent.

To all who have rendered aid in the preparation of the programs, thanks are given by the C.M.A. Committee on Scientific Work. It is hoped that members will make proper allowance for any inadequacies. In times such as the present, it is only possible to do as much as conditions permit. California Medical Association is grateful that in Los Angeles a local county medical unit of sufficient size exists, to make possible this year's meetings, thus avoiding a lapse of continuity in annual sessions.

C.M.A. REPORTS FOR YEAR 1944

Annually, the officers, committees and component county societies of the California Medical Association are requested to submit reports concerning activities carried on during the previous calendar year. Our Country being at war, many of the activities of scientific and organized medicine have necessarily been somewhat curtailed. Nevertheless, under these conditions, there is perhaps more reason than ever why reports on work done should become a matter of record. When such information is made available, it is possible for the constituted authorities of the State Association to measure values and come to clearer decisions on existing needs and future programs.

Members of the House of Delegates have a special obligation to scan financial and other reports. Through perusal of the digests of proceedings by bodies such as the Council, delegates will be able to consider to better advantage some of the problems that will be submitted when the House is in session. The reports which appear in the current issue will also permit all C.M.A. members to orient themselves concerning the work of the Association and its component units. It is gratifying to know, in spite of all the adverse influences now in operation, that continued progress in organized and scientific medicine was made in California during the twelve months of 1944.

Ten Commandments for High Blood Pressure Sufferers:

1. Thou shalt honor thy doctor's commands and obey them.
2. Thou shalt not eat nor drink to excess.
3. Thou shalt take life easy and live longer.
4. Thou shalt sleep eight hours every night.
5. Thou shalt rest one hour after noon meal.
6. Thou shalt not lose thy temper for any reason.
7. Thou shalt not brood nor worry over spilt milk.
8. Thou shalt not covet thy neighbor's wealth but work less.
9. Thou shalt not covet thy neighbor's dinner but eat less.
10. Thou shalt take thy doctor's prescription and nothing less.

The first treatise on diseases of the skin, *"De Morbus cutaneis"* (Venice, 1570), was written by Hieronymus Mercurialis, who was born in 1530 and died in 1606.

EDITORIAL COMMENT†

TUBERCULOSTATIC ACTION OF STREPTOMYCIN

Search for chemotherapeutic agents effective against gram-negative bacteria led to the discovery of two antibiotics: streptothricin[1] and streptomycin.[2] Both were obtained from nonpathogenic soil fungi. Of these, streptomycin was the least toxic and of greater clinical promise.[3] Unlike penicillin, which has no recognizable effect upon the tubercle bacillus,[4] streptomycin inhibits the in vitro growth of this organism. Several other antibiotics active against the tubercle bacilli were subsequently isolated by Waksman[5] from other soil fungi. None of these were superior to streptomycin.

A preliminary report of the therapeutic efficiency of streptomycin in the treatment of experimental tuberculosis of guinea pigs has been made by Feldman and Hinshaw[6] of the Mayo Clinic. Twelve male guinea pigs weighing approximately 500 grams each were inoculated subcutaneously in the sternal region with 0.1 mg. of a 16 day old culture of human type tubercle bacilli. Eight of these animals received no medicament and served as controls. Administration of streptomycin was started in 2 animals on the day of inoculation. With 2 other animals streptomycin therapy was delayed for 2 weeks. The daily streptomycin dose was set arbitrarily to 75 mg. or 2775 Waksman units. This daily dose was given in 5 divided doses at 3 hour intervals.

In the dosage used, streptomycin was apparently nontoxic. All four treated guinea pigs remained in apparent good health, each increased in weight, and there was no histological evidence of degeneration. Unlike the sulfone compounds, streptomycin did not induce a large, dark spleen.

Treatment was continued until the 54th day, when the initial supply of streptomycin was exhausted. Two control animals had died shortly before this date. The 4 animals receiving streptomycin and the 6 surviving controls were then killed for necropsy. Rather severe and widely distributed tuberculosis was noted in each of the 8 guinea pigs in the untreated control group. The average numerical index of severity was 81.9, based on the arbitrary selection of 100 to represent the theoretical maximal amount of tuberculosis possible. With the 4 treated animals the severity index was only 2.8 on the same scale, a reduction in severity index to about one-thirtieth of that of the control group. Among the 4 treated spleens, only one showed a macroscopic involvement. All 4 spleens, however, contained tubercle bacilli as determined by animal inoculation.

In a second experiment, 10 male guinea pigs weighing approximately 500 gm. were inoculated subcutaneously in the sternal region with the same strain of tubercle bacilli, and 10 guinea pigs with a second human strain of equal virulence. Five animals of each group were treated with a second preparation of streptomycin. The daily dose was at first 1750 Waksman units, increased to 3000 units as more highly purified streptomycin became available. With 3 animals of each group the treatment was begun on the day of inoculation. With 2 animals, treatment was delayed till the 15th day. Treatment was continued for 61 days, at the end of which time all treated animals and untreated controls were killed for necropsy.

The slightly impure preparation of streptomycin used in the initial stages of this series was tolerated less satisfactorily than the more highly purified preparation of the first series. Most of the treated animals lost weight during the first few days of treatment, though all gained weight by the end of the experiment. Necropsies revealed a marked and striking difference in the severity of tuberculosis between the treated animals and untreated controls. In the control group the average numerical index of severity was 67 per cent of theoretical maximum. In the treated animals the numerical index was but 5.8 per cent. Treatment therefore cut down the severity index of tuberculosis in this series to about one-twelfth of that in the untreated controls. Tubercle bacilli were not demonstrable in the spleens of 6 of the treated animals.

A third therapeutic test with streptomycin in which treatment was not begun till 49 days after inoculation is now in progress. The data thus far available, warrants the conclusion that purified streptomycin is a tuberculostatic substance well tolerated by guinea pigs, and that in guinea pigs it is capable of "exerting a striking suppressive effect on the pathogenic proclivities of the human variety of Mycobacterium tuberculosis."

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Nicholaus Leonicenus (1428-1524), physician and professor of medicine at Padua, Bologna and Ferrara, studied syphilis, and his conclusions were that it was infectious. The work in which he demonstrated his theory was published from the Aldine press in Venice in 1497.

ORIGINAL ARTICLES

Scientific and General

RADIOLOGICAL ASPECTS OF CERTAIN TROPICAL DISEASES*†

Lt. Comdr. L. H. Garland (MC), U.S.N.R.
Astoria, Oregon

THE airplane and the current world war have forced us to acquire a more active interest in certain diseases of other lands. Clinical information concerning some of these diseases is still relatively meager, especially as concerns their manifestations in otherwise healthy white men (subject to relatively brief or mild exposure). For this reason it may be timely to review the radiological aspects of some of the more common tropical and semi-tropical disorders, and to consider current opinions as to the value of irradiation therapy in one or two of them.

DENGUE

Dengue is one of the most important tropical diseases as far as morbidity is concerned. The radiologist should be aware of its clinical features, despite the fact that there are no characteristic x-ray findings. Patients usually show a high fever, severe pains in the joints and muscles, and leucopenia; some develop a rash and adenopathy. Many have pains referred to the eyeballs, with or without conjunctivitis. The disease is due to a virus transmitted by the Aëdes mosquito.

DYSENTERY

Bacillary dysentery. This disease, due to various species of shigellae, is of widespread distribution and may result in serious epidemics. In the acute stage, there are no findings of specific radiological interest. In the chronic stage, x-ray changes resembling those of *chronic ulcerative colitis* have been reported.

Amebic dysentery. This form, due to endameba histolytica, is also world-wide in distribution, but more common in tropical than in temperate regions. It may be acute or chronic; carriers are common. The chronic form sometimes shows features of radiologic importance:

a. *Colon:* Irritability and mucosal irregularities, especially in the proximal half of the large bowel. Occasional hyperplastic changes in the cecum and appendix. Some believe that cecal inflammatory changes without pulmonary disease should suggest amebic colitis. Bell[1] reported conical spasm of the cecum, with segmental irritability of the colon in a group of cases.

b. *Liver:* Enlargement of one or more lobes, with associated displacement of the colon or stomach, may be due to liver abscess. We have found this observation of gastric displacement of considerable value in two cases of amebic abscess of the left lobe of the liver. These abscesses may be single or multiple, and sometimes attain enormous size. Thorotrast hepatography will help in their localization.

c. *Lung:* Abscess of the lung, silent or otherwise, may occur, often by extension from a liver abscess. There are no pathognomonic x-ray findings.

d. Miscellaneous: Abscesses of the *brain* and other viscers are occasionally seen.

TYPHUS AND OTHER RICKETTSIAL DISEASES

These diseases, while of considerable clinical importance, present no roentgen findings of immediate interest with the possible exception of Q fever. In that disease, due to rickettsia diaporica or burneti, a patchy type of *bronchopneumonia,* confined to one lobe, has been reported. In scrub typhus or tsutsugamushi disease, variable degrees of myocardial dysfunction may ensue; suitable roentgen studies (including kymography) will often disclose evidence of *cardiac damage* in involved cases.

HELMINTHIASIS

This includes a large group of disorders, many of them nontropical in nature. Only the more important ones, which show some findings of radiologic importance, will be considered here.

Hookworm disease. This is usually due to Necator americanus or ankylostoma duodenale. In the former, *small bowel* changes similar to those seen in deficiency disorders, have been reported.[2] They may subside following vermifugation. In ankylostomiasis, patients may have symptoms of duodenal ulcer, apparently due to the presence of numerous hooklets in the duodenal bulb, with associated *duodenitis.*[3] The thickened mucous membrane, irritability and local tenderness disappear soon after administration of a vermifuge. We have seen only a few cases with such findings.

Strongyloidiasis. Due to strongyloides stercoralis, this infestation usually results merely in diarrhea. However, changes in the small bowel suggesting regional *ileitis,* and in the lungs (localized infiltrates) have been reported.[4]

Ascariasis. This is the commonest helminthic infection. The worms may be recognized in the course of a gastrointestinal examination as radiolucent shadows, occurring especially in the jejunum. They measure from 15 to 30 cm. in length and about 6 mm. in diameter. The gastrointestinal tract of the worm itself may be outlined with the host's barium at a twelve or twenty-four hour study. Occasionally, a bolus of worms causes intestinal obstruction.

It is of interest to note that the actual incidence of intestinal parasitism in Naval personnel returning from the Pacific theatre in the years 1942 and 1943 was quite low, according to Michael,[5] who published a brief table showing the then percentage distribution of the conditions.

TRYPANOSOMIASIS

There are two completely different forms of this disease, the African and the American. African trypanosoma rhodensiense, causes sleeping sickness, with its associated hepatosplenic enlargement. American trypanosomiasis, due to trypanosoma cruze, causes Chagas' disease, with acute or chronic cardiac disturbances. The African type is, of course, the greater health problem. No important or characteristic x-ray changes have been reported.

LEISHMANIASIS

Due to a minute parasite, the leishmania, this disease may be predominately visceral or cutaneous. The former, or Kala-azar, shows fever, anemia and hepatosplenic enlargement. It may be mistaken for malaria. Complications are numerous and frequently severe: they include pulmonary, intestinal and vascular disturbances. Cutaneous leishmaniasis appears in two forms: the oriental and the American. Both show ulcerating granulomas of the skin, especially of the face and upper extremities. The

* Read before the Section on Radiology, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the Navy Department.

† The publication of matter pertaining to one of the most important of these diseases is temporarily restricted by a directive of the Joint Security Control Board. The others will be considered in the approximate order of their clinico-pathological importance at the present time.

American type or espundia, shows mucosal lesions as well. It is common in South America. No characteristic x-ray changes have been reported.

FILARIASIS

Three different forms of filariasis are seen in men, the most important being that due to the minute worm formerly known as the filaria bancrofti but now known by the cumbersome title Wuchereria bancrofti. This is the most widely distributed of the filarial diseases, and is spread by several different species of mosquito.

Filariasis. Filariasis due to Wuchereria bancrofti and to Wuchereria malayi is of considerable interest to radiologists, both from the point of view of diagnosis and treatment. The incubation period varies widely, being usually from 3 to 12 months. In otherwise healthy adult white males, not subject to heavy or repeated infection, it may present few or *no* clinical symptoms. When symptoms are present, they usually consist of periodic attacks of superficial lymphangitis involving an arm or leg, with variable degrees of lymphadenitis. The lymphangitis is frequently "retrograde," extending distally from the point of initial development. Attacks of funiculitis, epididymitis and orchitis commonly occur. Hydrocele or scrotal edema may develop. These attacks of lymphangitis may be mild or very painful. They usually subside in a week or two, and may not recur for months or years. Some cases show repeated recurrences at short intervals. Edema, wheals and other allergic phenomena are seen.

After several attacks of lymphangitis, persistent edema and fibrosis *may* develop and the condition of elephantiasis appear. Such usually takes several years, and seems to occur chiefly in those who have sustained prolonged exposure, massive infestation or complicating pyogenic infection. In the late stages, chyluria, chylous ascites and chylous diarrhea may occur. Chyluria (probably better known as lymphuria) is due to rupture of dilated blocked lymphatics into the renal pelvis or ureters. If blood vessels rupture along with the lymphatics hematolymphuria results. Some cases of chyluria show no symptoms; others have marked weakness, abdominal pain and depression. The deformity of the renal pelvis produced by the dilated lymphatics has been correctly diagnosed by urography.

In some patients the worms die and become calcified, producing small opacities, especially in the subcutaneous tissues, lymph nodes and the scrotal lymphatics. These appear as small linear or dot-like shadows from 1 to 4 mm. in length and only about 1 mm. in diameter. Some observers have reported opacities up to 12 mm. in length.[6] They are often difficult to recognize, but are fairly characteristic, having a different distribution from calcified trichinae, and being much smaller than cysticerci.[7] We have x-rayed the extremities and scrotal areas of about one hundred cases of filariasis in white adult males, all with infections of less than two years duration, without succeeding in demonstrating calcified worms in any of them. The worms are said to live from 1 to 7 years and probably few were adequately calcified, even if dead, in the short time elapsing since infection in our cases. The female worm measures up to 6 cm. in length and 0.25 mm. in thickness; the male is about half that size. They are often found coiled up in a node and occasionally in a thickened lymphatic. They have been recovered alive from infected nodes, by immersion of the excised node in warm saline for several hours; the worm resembles a small piece of white thread.

It is to be noted that the outstanding symptom and sign of filariasis is *lymphangitis*, and that the microfilariae are rarely discovered in the blood in the early stages of the disease, at least in current cases of W. bancrofti infestation arriving from the South Pacific area. Diagnostic skin tests are under investigation but no really satisfactory one has yet been reported. Some authorities regard biopsy of involved nodes as inadvisable because of a tendency to initiate recurrences. A reliable skin test will therefore be all the more desirable.

In those patients who have significant pain, soreness or other disability associated with the attacks of lymphangitis or lymphadenitis, considerable palliation and actual arrest of an attack can often be secured by irradiation of the involved areas. We use small doses administered to wide fields (from 50 to 100 r, air, with fields not less than 20x20 cm.), and radiation with moderate filtration, half-value layer equivalent to about 0.5 mm. copper. This dose is given to the involved regions every three days for about four doses. The treatment occasionally causes a temporary accentuation of symptoms for about twenty-four hours and may induce a brief abortive attack in a previously quiescent area.

Onchocerciasis and Loiasis. These two types of filariasis are less common than the above. Onchocerciasis is due to onchocerca volvulus (the blinding filaria): patients show tender subcutaneous nodules, especially on the head, and sometimes keratitis and blindness; an itching lichenoid dermatitis may develop. It is seen in West Africa, and Central and South America. Loiasis is due to filaria loa loa: patients have subcutaneous swellings; and the parasite may migrate to the subconjunctival tissues. Note that the "blinding" filaria causes intrinsic eye changes due to migration of microfilariae into the eye structures, while the loa loa merely causes temporary inconvenience (when the worm passes across the subconjunctival tissues—a rather striking episode, well recorded in colored motion pictures.)

Dracontiasis. This is due to Dracunculus medinensis, the guinea worm, formerly classified as filaria medinensis, and considered in this section for that reason. The male worm is about 2 cm. in length, and the female from 15 to 100 cm.. Each measures from 1 to 2 mm. in diameter. They may produce no symptoms until the skin is punctured over them, usually at the point of emergence of the head. If retained after it dies, the worm often calcifies and appears as a segmented, linear or coiled shadow. The worms have been found in various parts of the body, especially in the subcutaneous tissues.

DISTOMIASIS

This group of diseases is due to trematodes or flukes. *Intestinal distomiasis* is due to a variety of trematodes, especially fasciolopsis buski. In the latter type, oedema may supervene on prolonged diarrhea.

Hepatic distomiasis is due commonly to clonorchis sinensis. Liver enlargement, jaundice, etc., are seen.

Pulmonary distomiasis is due to Paragonimus westermanii. The worm is actually found in many of the organs besides the lung, but pulmonary symptoms tend to predominate. Ova may be recovered from both sputa and excreta: they are small, brown and operculated (measuring from 65 to 100 microns in length). The fluke itself measures about 8 mm. in length and 2 mm. in thickness. In chronic cases it causes small cystic lesions in the lungs, with associated inflammation and ulceration. Roentgenograms may reveal nodular thickening of the pulmonary markings, especially in the lower lobes, with variable degrees of bronchiectasis and even cavitation. The concomitant blood spitting gives rise to the term "endemic hemoptysis." Undoubtedly a better term is *paragonimiasis*.[8] The following four clinical types are recognized: 1. A generalized lymphonodular type, with fever, adenopathy and cutaneous ulceration; 2. A pulmonary type with cough, chest pain, bloody or purulent sputum and variable roentgen findings in the lungs; 3. An abdominal type, with pain, tenderness, variable degree of diarrhea, hepatomegaly and other findings; and 4. A

cerebral type, with various convulsive, paretic or other findings. It is reported that in some sections of Japan, cerebral paragonimiasis is included in the routine differential diagnosis of cases of epilepsy.

We have seen some eight cases of pulmonary paragonimiasis in personnel returning from the South Pacific area, and have made complete roentgen examinations of the lungs of all of them. Only 2 showed significant degrees of nodular thickening of the basal pulmonary markings bilaterally. The findings were not in the least diagnostic per se, but in conjunction with the history of intermittent cough and hemoptysis plus appropriate exposure, they were of some value in diagnosis. In all eight cases, the eggs were found in the sputa. None showed gross bronchiectasis, nor were the "shadows of the fluke" ever visible in any of the films. Miller and Wilber[9] have described in detail the clinical features of 3 of these cases, and are responsible for bringing this unusual condition to our attention. In two of their cases severe and persistent thrombophlebitis of the legs was present. In none were cerebral symptoms prominent.

Schistosomiasis. This is due to a group of blood flukes. Three types are seen in men: Bilharziasis or endemic hematuria, due to schistosoma hematobium; Rectal or intestinal bilharziasis, due to S. mansoni; and Oriental schistosomiasis, due to S. japonicum (with which type liver symptoms predominate).

In infected countries, a high percentage of the population is afflicted with bilharzia (native involvement running up to 60 per cent). The mode of infection is through an abrasion in the skin. All organs of the body are affected, the genito-urinary and gastro-intestinal tracts being the most commonly and most severely involved. The clinical diagnosis is said to be simple, the principal symptom being bleeding from the urinary or gastro-intestinal tract. The diagnosis is confirmed by finding the ova in the excreta. The ova become deposited in the submucosa, giving rise to ulceration and subsequent caldification, which can be shown roentgenographically. Two forms of reaction are observed: (1) calcific streaks in the walls of involved areas, (2) oval densities like stones or calcified papillomata.

The first form is predominant in the bladder and ureters. The second form is found commonly in the intestines and the kidneys. Papillomas in the intestinal tract are not usually calcified, except in the region of the appendix. Those occurring in the kidneys are usually calcified, causing shadows which resemble stones. The calcifications in the urinary tract are fixed in position and may not increase in size even in the course of years. They do not encroach on the lumen, as they are embedded in the mucosa. The calcified papillomas are readily seen roentgenographically, the uncalcified ones by the aid of opaque media. The bladder is usually the first organ to show evidence of the disease.[10]

Cases of pulmonary nodulation, due to ova or adult worms reaching the lungs, and resembling miliary tuberculosis, have been reported in both the urinary (S. hematobium), and the intestinal (S. mansoni) forms of the disease.[11,12]

TENIASIS

This group of diseases is due to cestodes or tapeworms. a. Diphyllobothrium latum, the broad tapeworm, causes few serious symptoms except anemia. It measures from 2 to 10 meters in length. b. Taenia solium, the pork tapeworm, causes variable symptoms, usually mild. It measures about 2.5 cm. long. Its larval form, the cysticercus callulosae, causes *cysticercosis.* Cysticercosis is usually acquired by eating "measly" pork, and may be associated with serious symptoms. The larvae may occur in any organ in the body, but especially in the brain and eye, any symptoms vary accordingly. In the brain, they may cause epilepsy; in the eye, visual aberration; in the muscles rheumatism, and so forth. When calcified, which usually takes five years or more after infestation, the larvae become visible on roentgenograms. In the brain they show as small opacities, 1-3 mm. diameter, scattered through the substance of the organ. In the muscles (where they are much more apt to become calcified than in the brain) they usually appear as ovoid densities, about 2 x 10 mm. in size, lying in the direction of the muscle fibres They range from one to several thousand in a single patient, and may vary greatly in size and shape.[13,14] In the differential diagnosis of brain lesions, tuberous sclerosis may be considered but does not show any associated skeletal muscle calcifications. There are other unusual inflammatory and degenerative cerebral conditions in which patchy calcification occurs, but space does not permit consideration of them here. In the differential diagnosis of muscle calcifications there is usually little difficulty: in trichinosis they are only about 1 mm. diameter; in calcinosis interstitialis they are usually linear and diffuse. c. Taenia saginata, the beef tapeworm, occurs in man only in adult form, and is not associated with any specific findings of immediate interest.

d. Taenia echinococcus (now known as Echinococcus granulosus), the dog tapeworm, is seen in man only in its larval form, and causes hydatid disease or *echinococcosis.* While not strictly speaking a tropical disease, this condition occurs sufficiently often in persons returning from overseas (especially Australia and Iceland) to be worth considering here. The echinococcus cyst or hydatid is formed by liquefaction of the larva after it has invaded the tissues. It grows slowly and its wall is composed of two layers, an external laminated cuticle and an internal germative layer (a fact of diagnostic value in some pulmonary hydatids[15]). The cysts may be simple or complex: some are sterile, some become secondarily infected. They may rupture into hollow viscera, such as bronchi, intestinal tract, biliary tree and urinary tract.

Hydatid cysts occur most frequently in the liver (over 50 per cent of cases). They also occur in the lungs, pleura, abdominal viscera, bones and, rarely, in the nervous and cardiovascular systems. Some are small and symptomless, others are large and produce serious symptoms. In solid viscera, such as the liver, cysts tend to undergo calcification of their walls, while in non-resistant organs, such as the lungs, they rarely or never do so. In bone, a patchy cystic appearance develops, resembling fibrocystic disease or osteolytic metastatic carcinoma; the ribs and pelvis are common sites. In the brain they have been diagnosed by aspiration and air filling. In the lungs, well defined circular opacities occur; they may be quite large but usually vary from 3 to 8 cm. in diameter. Bone and lung lesions may coexist.

TROPICAL TREPONEMATOSES

This group includes yaws, pinta and bejel, all granulomatus diseases due to treponemata, and rarely seen in this country. In their chronic or late stages, lesions of bones and viscera may occur, *similar to those seen in syphilis.* We have seen a case of *yaws* in an officer who accidentally infected a finger while in the South Pacific area. He developed a nodular granuloma at the site of inoculation, with regional adenopathy, and a rash; treponema pertenue was found on dark field study. The lesion regressed promptly with bismuth treatment. In some endemic areas, peculiar tertiary forms of yaws are seen: (a) goundou, a chronic sclerosing osteoperiostitis of the superior maxillae, and (b) gangosa, a destructive ulcerating process of the nose and palate, especially of the cartilaginous portions. Cangosa may be also due in rare instances to cutaneous leishmaniasis. The x-ray appearance of such advanced lesions is readily visualized.

Pinta, due to the treponema carateum, is seen in Cuba, Mexico, and Central and South America. It may result in various viscera lesions, including aortic aneurysm, similar to those of tertiary syphilis. There are no characteristic roentgen findings.

MISCELLANEOUS LESIONS

Tropical Ulcers: Various types of tropical ulcers (sloughing phagendena) may be encountered, especially of the feet, hands and face. These are commonly due to spirochetal and bacillary organisms. They often extend to adjacent bones and joints. X-ray changes are those of severe infectious osteitis or osteoarthritis. In recent months there have been reports of pathogenic diphtheria bacilli being found in some tropical ulcers and desert sores. These have occasionally been virulent and associated with characteristic paralysis and other symptoms.

Ainhum is clinically equivalent to spontaneous amputation of the little toe; it is apparently a neurotrophic disorder. Films show atrophy or disappearance of the phalanges.

Madura foot or mycetoma, is a fungus infection, usually involving the foot and resulting in chronic swelling, ulceration and sinus formation. The bones and joints show varying degrees of destruction and osteoporosis.

SUMMARY

The radiologist can be of significant assistance in the diagnosis of several tropical disorders, by paying due attention to certain disturbances of spleen, liver, intestinal tract and lung. In occasional instances, lesions of bone, brain and eye will provide a clue to the nature of the underlying condition

The principal roentgen diagnostic points of several tropical and subtropical conditions are outlined briefly in this article. The beneficial effects of radiation therapy in connection with a few of the diseases is mentioned.

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Time is of the essence of the damage in shock. Treat promptly; still better, recognize early.

Be not the niggard, nor yet the zealot, in treating shock. Enormous quantities of parenteral fluids may be required; yet they must be judiciously chosen in quality and quantity.

A STUDY OF PNEUMONIA IN SAN FRANCISCO, 1943-1944*

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Introduction.—It is the purpose of this paper to review 150 patients with pneumonia entering a medical service (University of California) at the San Francisco Hospital in the twelve-month period from July, 1943, to July, 1944.

It must be mentioned that many of these patients had a subnormal general condition in association with alcoholism, and came from a low economic level.

No patients were included in this series whose diagnosis was in doubt or whose pneumonia was definitely secondary to other disease processes. In all cases the diagnosis of pneumonia was substantiated by a positive x-ray of the chest.

ETIOLOGICAL CLASSIFICATION

Of the total of 150 patients, 139, (92.6 per cent were due to the pneumococcus; 5 (3.3 per cent) were considered as being primary atypical pneumonia (virus), and 3 (2.0 per cent) were caused by Friedlander A bacillus. There were 2 cases due to Bacteriodes organisms, and one due to beta hemolytic streptococcus. (Table 1.)

TABLE 1.—*Etiological Classification of 150 Cases of Pneumonia.*

	Number cases	Number deaths	% Mortality
Pneumococcal	139	31	22.3
Primary Atypical Pneumonia	5	0	0.0
Friedlander A	3	0	0.0
Streptococcus	1	0	0.0
Bacteriodes	2	2	100.0
Total	150	33	22.0

Since the pneumococcus was responsible for the majority of the cases of pneumonia (92.6 per cent) they will be discussed in detail. Other etiological agents were responsible in too few cases to warrant discussion.

Of the 139 cases of pneumococcus pneumonia, 71.2 per cent occurred in men, and 28.8 per cent in women. Approximately two-thirds of the men and one-half of the women were over the age of 40, indicating that an older age group was involved.

Among the 139 patients, typeable pneumococci were isolated in 105. The remaining 34 patients either died before pneumococcus typing could be done or their sputa would not type. Pneumococcus type VII produced the highest incidence, being found in 21.9 per cent of the 105 patients. Type I was the etiologic agent in 19.1 per cent, and Type XXV and Type IV were each responsible for 6.6 per cent. The remaining types were fairly equally scattered among the rest of the series. One case was due to the relatively rare Buckley strain. (Table III.)

In the four-month period from December through March 59 per cent of the cases occurred. There was no definite monthly or seasoned correlation with any specific pneumococcus type.

TREATMENT

All patients with pneumococcus pneumonia were treated with sulfonamides. Sulfadiazine was used in the majority

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TABLE 3.—*Relationship Between Pneumococcus Types, Blood Cultures, and Mortality.*

Type	% Incidence	Number Cases			Number Deaths			% Mortality	
		Total	— blood culture	+ blood culture	Total	— blood culture	+ blood culture	— blood culture	+ blood culture
VII	21.9	23	12	11	8	1	7	8.3	63.3
I	19.1	20	8	12	2	0	2	0.0	16.6
XXV	6.6	7	4	3	3	1	2	25.0	66.6
IV	6.6	7	4	3	1	0	1	0.0	33.3
All others		48	27	21	13	4	9	14.8	42.8
Total typed cases		105	55	50	27	6	21	10.9	42.0

(70.5 per cent) and sulfamerazine in 18 per cent. A few patients received sulfathiazole. No perceptible difference in the action of these drugs was noted.

The initial doses were uniformly 4 grams orally followed by 1 gram every four hours (sulfadiazine) or 1 gram every eight hours (sulfamerazine). This dosage was continued until satisfactory clinical response was produced and the patient remained afebrile for two days. Those patients whose general condition was poor on entry or whose infection appeared overwhelming received an initial 5 grams intravenously in 1,000 cc. of lactate-Ringer's solution. Adequate doses of sodium bicarbonate were given to maintain the pH of the urine at approximately 7.0. Patients with type VII pneumonia whose blood cultures were positive received when possible sulfadiazine plus type specific antipneumococcus serum (rabbit) in amounts of 300,000 units. All patients with white blood counts less than 6,000, irrespective of type, received similar treatment. Penicillin was used in only 2 cases and therefore no conclusions can be drawn.

Complications during the course of pneumonia were treated as they occurred. Peripheral vascular collapse was treated with coramine, nasal oxygen, and plasma. Pulmonary edema was treated with plasma, intravenous aminophylline and hypertonic glucose. Response to these measures were uniformly poor.

Complications directly resulting from sulfonamide treatment and necessitating cessation of the drug occurred in only 2 cases. There were no deaths attributable to use of these drugs.

COMPLICATIONS

Complications occurred in 25.2 per cent of the patients, and were distributed as follows: Peripheral vascular collapse and pulmonary edema in 11 cases with a mortality of 81.8 per cent; empyema in 10, with a mortality of 30 per cent; endocarditis in 5, with a mortality of 100 per cent; sterile pleural effusion in 4, with a mortality of 50 per cent; meningitis in 3, with a mortality of 100 per cent, and lung abscess in 2, with a mortality of 100 per cent. (Table 2.) Pneumococcus type VII was responsible for 48.5 per cent of the above complications.

TABLE 2.—*Relationship Between Mortality and Complications.*

	Number cases	Number deaths	% Mortality
Empyema	10	3	30.0
Sterile pleural effusion	4	2	50.0
Peripheral vascular collapse and pulmonary edema	11	9	81.8
Endocadritis	5	5	100.0
Meningitis	3	3	100.0
Lung abscess	2	2	100.0
Total	35	24	68.6

DISCUSSION OF MORTALITY

Among the 139 cases there were 31 deaths, giving a mortality of 22.3 per cent. This figure is considerably higher than the mortality of 11.0 per cent reported in another and larger series of pneumococcus pneumonia from this locale.[1] Our interest is centered on these patients who failed to recover.

Of the 31 deaths, 23 were men and 8 were women. Of the deaths 84 per cent were among those patients 40 years or over. Of those patients having three lobes involved 58.4 per cent died. There was no statistical correlation between mortality and single or double lobe involvement. Pneumococcus type VII was responsible for 21.9 per cent of the cases and for 29.6 per cent of the deaths. Pneumococcus type I on the other hand was responsible for almost as many cases (19.1 per cent) but had a mortality of only 7.4 per cent.

Approximately one-half of all pneumococcus pneumonia patients had a white blood count between 10,000 and 20,000. Nine patients had a white blood count of 5,000 or less. This finding was of extreme importance because the mortality in this group was 100 per cent.

A positive blood culture definitely increased the mortality. (Table III). Blood cultures were taken in all 139 cases. In the 105 typed patients blood cultures were positive in 47.6 per cent. The mortality of these patients with positive blood cultures was 42 per cent. The mortality of the patients with negative blood cultures was 10.9 per cent. Pneumococcus type VII again was particularly virulent, producing death in 63.3 per cent of those patients with positive blood cultures.

SUMMARY AND CONCLUSIONS

1. In the twelve-month period from July, 1943, to July, 1944, 150 patients with pneumonia were seen on the University of California medical service at the San Francisco Hospital.

2. The pneumococcus organism was responsible for 92.6 per cent of the cases; type VII pneumococcus pneumonia occurred most frequently followed closely by type I.

3. The treatment of pneumococcus pneumonia with sulfonamides and adjuvant measures was briefly outlined.

4. Serious complications which were frequently fatal occurred in 25.2 per cent of the patients with pneumococcus pneumonia. Pneumococcus type VII was responsible for 48.5 per cent of these complications.

5. A mortality of 22.3 per cent was found among the patients with pneumococcus pneumonia. It is felt that this high figure is due in part to the age and poor physical condition of the patients treated, and to the local virulence of the type VII pneumococcus.

6. The influence of a positive blood culture, leukopenia, and lobe involvement on mortality was noted.

7. It is suggested that type VII pneumococcus infections be strenuously treated in this locale.

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One who was celebrated for his comedies which were successfully produced, and for his operations for stone was Jacob Rueff (1500-1558), town physician at Zurich.

ARTERIAL SPASM AND FAT METABOLISM: THEIR RELATION TO CERTAIN DISEASES AND TO CERTAIN MEMBERS OF THE VITAMIN B COMPLEX

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IN collaboration with Dr. Agnes Fay Morgan at the Department of Home Economics laboratories in Berkeley, California, the author of this preliminary report has been engaged for several months in studying the bloods of a series of tuberculosis patients from the California Sanatorium at Belmont. Also a number of patients having cardiovascular diseases; some patients having Meniere's Disease; a few allergic patients and a few aging people with very few physical defects. Microbiological methods were used in carrying on these studies.

Previous observations by other investigators[1] apparently have proved the relationship of choline deficiency to fatty liver, and that the administration of choline may need the addition of inositol and pyridoxine to help in the relief of the condition. It has also been shown that choline[2] is necessary in certain cases of Vitamin A deficiency to pull the A factor into the blood stream. From this it would appear that a combination of the B complex appears to be the factor missing, and that is needed by Vitamin A, for an improvement or prevention in the common cold-catching tendency.

Microbiological studies show that pantothenic acid plays a very important rôle in the metabolism of fat—indeed, in Agnes Fay Morgan's study of the dog, Benny, made gray-haired by this deficiency, an autopsy showed a very diffuse deposit of fat in the liver. Blood riboflavin, pantothenic acid and in a few patients, nicotinic acid, were found to be low in our series of cases.

Thirty-seven patients have been studied. These, according to their diseases, were listed: tuberculosis, 10; cardiovascular, 13; hypertension, 5; coronary disease, 2; arteriosclerotic disease, 3; intermittent claudication, 2; Meniere's Disease, 4; migraine, 1; arthritis, 1; allergy, 1; tinnitus aureus, 2; nerve deafness, 1; no specific diagnosis, 4.

Nearly all patients showed increase of blood fat—cholesterol. This finding has an added importance because of the reports of Leahy and his group in Boston, that animal fats, such as egg yolk, cream, and butter, appear to play an exceedingly important rôle in arteriosclerosis. The importance of cholesterol in coronary disease has recently been emphasized.[3] Cholesterol also appears to hold a definite spot among the various factors associated with Meniere's Disease.

From these preliminary studies, it is suggested that the combination of the factors of the B complex known to influence blood vessel spasm, plus all the other unknown factors, promise considerable relief, especially when used early, in many conditions known to be related to spasm. In more davanced cases extremely large doses are necessary.

It is quite possible that more extensive laboratory studies of the bloods of a large group of cardiovascular patients may prove that these involve a disturbance of fat metabolism, just as diabetes is due to a defect of sugar metabolism. The author would be happy to receive comments on the suggestions above made.

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IS THE ORGANIZED MEDICAL PROFESSION ANTISOCIAL?

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Foreword.—The article which follows was sent to CALIFORNIA AND WESTERN MEDICINE, in January, 1942. This contribution by Dr. Porter, former Dean of the Medical School of the University of California, should be of special interest to members of the California Medical Association, in relation to the proposed compulsory sickness insurance bills that are now under consideration by the California Legislature.—*Editor.*

IS the organized medical profession antisocial? Does our community of citizens get the best medical service that the 180,000 medical men of the United States is competent to give?

Are there too many specialists. Has medicine lost Hippocratic spirit, forgotten that "where there is love of the art, there also is the love of man"?

Has it become greedy and lustful for wealth? Has it become trade-minded and organized itself as a trade union allowing the material interests and its craft pride to dominate and direct it?

To the grief and embarrassment of American doctors these questions are being asked and asked again. And the doctors conscious that medicine has advanced more in the past fifty years than in any previous 5,000 are bewildered and embarrassed at what they take to be a vicious unwarranted attack. Yet they know that it is no new thing that their profession has been the target of abuse ever since the healing art first tried to free itself from magic.

Robert Hutchinson's anthology "For and Against Doctors" quotes comments on physicians written in various epochs from the 6th century B. C. to the 20th century A. D. and the againsts loom larger by far than the for. The Doctor, sore and surprised, taking stock of his detractors finds that the most vociferous and unrelenting of these are in the group of the social service workers, a profession new born in the 20th century and as he regards them and their volunteer satellites and sympathizers his gorge rises and he is impelled to ask some questions—cogent and barbed questions to match those the social service group hurl at him.

What does the social worker know of physiology and pathology of the causes of disease, pharmacology, therapeutics and pharmacy? Not knowing these things what right has the social worker to judge what is and what is not adequate medical care?

Has not the social service worker an ego so inflated that only his own opinion bears any weight? Is it not true that the Lady Bountiful complex has overbalanced the judgment of social workers who dispense not their own monies, but tax funds or philanthropic contributions? Is it not true that the loss or lack of judgment creates the blind spot that prevents the social worker from being just to the profession which has worked so successfully to wipe out disease that the communicable diseases which were scourges fifteen, even thirty years ago today are almost forgotten. Does not that same blind spot prevent

them from admitting that nowhere in the world nor at any period in history has such superlative medical service been available to any people as live in the United States in 1938. Is it not true that the social worker group seizes upon the few crooks, incompetents and careless that the medical profession as a human institution must include and set up their errors and crimes as typical of the whole profession's care of the sick and interest in the human welfare.

It is hardly probable that the doctor and the social worker could be brought to agree about the character and extent of the doctor's task nor about his place in society, and equally it is doubtful if either one's ideas on the subject would agree with the thoughtful citizen in his estimates.

The citizen who is not friend, or aid, or wife, rarely gives the doctor a thought except when fear of death or pain or a demand for payment of the services a doctor has rendered arouses him.

No one untrained in medicine can possibly visualize what a doctor really can accomplish, nor the limitations of his power to accomplish, and only a few can understand the sources of those powers and limitations. Nowhere is the proverb "a little knowledge is a dangerous thing" better illustrated than in the case of the social worker whose training gives a glimpse, and no more, of the surface aspects of the doctor's problems, but in a light that does not and cannot illuminate the depths? Like all other people without medical training the social worker's opinions about the work of doctors must be tinctured by emotions aroused by contact with sick people and the doctors who serve them. Emotion is a certain inhibitor of clear observation and judicial minded deduction. It matters not whether the emotion is love or hate, sympathy, professional pride or personal egotism.

On behalf of the social worker it can be said that the doctor basks his ego in the sunlight of that authority which has come down to him through the ages—an authority that began in the past whose beginnings are lost in the temples that were ruins when the temples of Aesculapius began to flourish in Greece. Insensitive as some of them may be to spiritual things, faced by pain, by birth, by death, by the loss of reason the hard bitten race of moderns still admits that there are mysteries inherent in existence. Face to face with these mysteries almost any mortal is fearful and reaches out eagerly for comfort, for a comforter and has faith in the magic name "physician." And it is another of existence mysteries that so rarely is their faith in the frail human being, the physician, betrayed.

The social worker also can plead, and truly, that the doctor's training tends to make him interested in diseases rather than in health and the individual who has been broken under the stress of life secures his care and effort, rather than the individual who is threatened with breakdown. Repair, the cobbling of broken bodies, rather than preventing, the accusing voice declares, is his preoccupation, and here the testimony is strengthened by what the public health officer has to say of his colleague, the practitioner. Such comments rouse distrust in the medical profession. Do these critics ever emphasize the enormous burden of free and almost free-care the doctors of the United States assume on behalf of the needy who are under financial stress, not by any means all of them indigent?

Do these critics of the doctor, they who are self righteous and ignorant, take pains to find out what the doctors job is? What he gives, what his patients receive? Do they consider for a minute that relation of patient to doctor, that relation of friend to needy friend? They do not! Or at least the doctor they so bitterly attack, believes that they do not.

And finally the physician asks: How far are they influenced by the advantages and social importance that will accrue to their own profession if they can displace the medical profession from its present status of authority and social importance? Furthermore as an individual with a firm faith in what he believes to be the superior way of American democracy, he asks to what degree does this attack represent the social workers conversion to and enthusiast's evangelization for collectivism and paternal state? Such are the questions formulated by one side and the other, and hurled like hand grenades across the entrenchments of dislike and misunderstanding!

Truth is at the heart of each of these questions. But as in every other controversy, neither side has been willing carefully to examine the other's: point of view, contentions, rights and ways. In these times, in every social field, the murk of a myriad opinions obscures the light of truth. Nowhere is the fog thicker than in the field of medical service to the modern American community.

PENICILLIN TREATMENT FOR GONORRHEA*

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Riverside

DURING the past nine months, 225 cases of gonorrhea have been treated with penicillin at this Station Hospital. The results obtained and the impressions gained by the medical staff may be of benefit to those members of the medical profession who will soon be using the drug for the first time.

The penicillin was administered in different dosages and at varying time intervals, depending upon the project then under investigation. A more complete paper giving the results of these different methods of administration will soon be published by other authors, through whom the results of this particular group of cases, as well as several other groups, must be cleared; however, it is felt that the impressions and experiences of one who has treated these patients first-hand will be of interest. In order to more clearly bring out the different points of interest, the data to be presented will be divided into three different groups determined by the method of treatment used.

NOT A "CURE-ALL"

It should be emphasized at the beginning of this paper that while penicillin is a drug of greater potency and value against gonorrhea than any other available therapeutic agent, it is still not a "cure-all" and will not produce 100 per cent results by itself. The factors of patient coöperation, proper hygiene, systematic care and careful "follow-up" are still of primary importance. When one has the responsibility of treating patients. these factors loom ever and ever more important and they are points that will not appear in any column of figures or statistics. For that reason special mention is made of them at this early point in the paper.

* From the Station Hospital, March Field, California, December, 1944.

Note. It is desired to express due appreciation and thanks to Pfc. Felix Haupel and Pfc. Donald Nichols of this hospital command, whose conscientious thought and efforts in maintaining the necessary records throughout the gathering of this material, made the results of definitely greater value.

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CLINICAL MATERIAL

During the nine months' period wherein the above patients were treated, the drug has been used upon various classes of military personnel and the technique of administration has been varied from time to time. This has been necessary because of the changing demands for different types of trained personnel in the combat areas and hence a fluctuating need for rushing these men to these areas. As the drug became more available, it was used in all classes of personnel, but at first it was used solely in those classes for whom there was pressing need in the front lines in order that their cure and convalescence could be speeded as much as possible. Also as the supply of the drug increased and more military personnel treated, the method of administering the drug has varied and the time allotted for the "follow-up" treatment of the patient increased. This led to a better "criteria of cure" developing and eventually more information being obtained. Thus not all the cases which will be recorded in this paper were followed for the same period of time or by the same methods. The variations will be described as they occur.

GROUP I

The First Group of cases is that wherein the penicillin was administered in a total dosage of 75,000 units, administered in 15,000 unit doses, intramuscularly, at three hour intervals. The project was originally set up for flying personnel who had had no previous sulfonamide drug therapy, but as it later developed, 41.2 per cent of the 39 patients treated in this group had had previous chemotherapy. The average "follow-up" period for this group of patients was only about two weeks after the penicillin was given. The results of treatment in this 75,000 unit group are shown in Table I. It will be noted that there are eight failures and it is of interest to know that all of these eight patients were relieved of symptoms and urethral discharge for a period of 2½ to 10 days before the urethral discharge recurred or the routine morning urine cultures taken during this period became positive for gonococci.

TABLE 1.—*Primary Treatment of Group One. Patients Using 75,000 Units*

Total cases treated	39	
Cases cured	31	79.4%
Cases not cured	8	20.6%

Table 2 shows the results of retreating the above eight cases of failure with 100,000 units of penicillin. The single case of failure from this group responded satisfactorily to another trial of therapy using 200,000 units of penicillin which was given in doses of 20,000 units every two hours for ten doses. Thus of the original thirty-nine patients in the group all were apparently cured eventually. It must be again stressed that the average period of "follow-up" was only two weeks and that the criteria of cure used were simply: (1) absence of urethral exudate, (2) a clear two-glass urine test and (3) negative urine cultures during the period of observation. The inadequacy of this "follow-up" and determination of cure will become apparent when the results of the group of patients treated with 50,000 units of penicillin are discussed.

TABLE 2.—*Second Treatment of Group One. Patients Using 100,000 Units*

Total cases treated	8	
Cases cured	7	87.6%
Cases not cured	1	12.4%

GROUP II

The Group Two patients received 100,000 units of penicillin in five doses of 20,000 units each at three hour intervals. 82.1 per cent of these had had previous sulfonamide drug therapy. Again it was not possible in the greater proportion of cases to check the patient for more than a period of ten to fourteen days. Tables 3 and 4 give the results of this type of therapy.

TABLE 3.—*Primary Treatment of Group Two. Patients Using 100,000 Units*

Total cases treated	116	
Cases cured	106	91.3%
Cases not cured	10	9.7%

The results of retreatment in the 10 failures listed in Table 3 will be given in Table 4, which follows.

TABLE 4.—*Second Treatment of Group Two. Patients Using 100,000 Units*

Total patients treated	10	
Patients cured	10	100%
Patients not cured	0	0%

Thus of the 116 patients to receive initial treatment with 100,000 units of penicillin, 91.3% responded favorably to the first course of therapy and the balance of the patients responded to the second course. Probably the actual rate of cure is less than this because as was mentioned before, the "follow-up" period was not sufficiently long and procedures such as prostatic massage and urethral soundings were not performed. It is significant to note that of the ten cases reported as failures, four of them had none of the ordinary signs and symptoms of gonorrhea, such as urethral discharge, dysuria or cloudy urine. These four were detected by culturing the gonococcus from the urine and had this procedure not been performed repeatedly, there is no doubt but that they would have been considered as cured until such time as they either recurred or infected someone else.

GROUP III

The Third Group of patients was treated using 50,000 units of penicillin in five 10,000 unit doses administered at one hour intervals. Inasmuch as the supply of penicillin for use was now greater and the class of military personnel eligible for treatment was such as could be maintained near the hospital for adequate periodic examinations, it is this group of data that is most revealing. These patients were all followed a minimum of 30 days and many of them kept under surveillance sixty days. In addition urethral soundings and prostatic massage, carefully done at the proper times, were performed.

Table 5 shows the results obtained in treating this group of patients with the first course of 50,000 units of penicillin.

TABLE 5.—*Primary Treatment Group Three. Patients Using 50,000 Units*

Total patients treated	70	
Patients cured	43	61.4%
Patients not cured	27	38.6%

It will be noted in Table 5 that there were 27 failures in the first course of 50,000 unit treatment but in Table 6 only 20 patients received retreatment. The remainng seven patients were treated with 100,000 units rather than the 50,000 unit second course because it was imperative that they return to duty in the shortest possible time and that their chances of recurrence be minimized. With the exception of one, all these patients responded satisfac-

torily. This one patient was later retreated with 200,000 units and also failed with this dosage. He is listed among those cases later reported in Table 7 herein as complete penicillin failures. The results of retreating the remaining twenty patients with another course of 50,000 units of penicillin are tabulated in Table 6.

TABLE 6.—*Second Treatment Group Three. Patients Using 50,000 Units*

Total patients treated	20	
Patients cured	9	45%
Patients not cured	11	55%

COMMENT

It may be seen that more than half the patients who failed to respond to the first course of treatment also failed the second time. In the Group Two class of patients who were treated with 100,000 units as initial treatment and who were previously discussed, the response to the second course of penicillin was much better. This suggests the possibility that a small initial dose of penicillin leads to the patient becoming penicillin-resistant and that if an adequate primary dose is given, this is less likely to occur. More will be said regarding this important possibility later. The eleven failures reported in Table 6 and the one failure mentioned earlier among the seven patients treated with 100,000 units, were given 200,000 units of penicillin in 40,000 unit doses at intervals of three hours. This made a total of twelve patients to be treated in this manner. Table 7 presents the results.

TABLE 7.—*Third Treatment Group Three. Patients Using 200,000 Units*

Total patients treated	12	
Patients cured	8	66.6%
Patients not cured	4	33.3%

Thus of the original seventy patients in Group Three receiving initial 50,000 unit courses of penicillin, 94.3% obtained an eventual cure although a considerable number of them had to be retreated one and two times and 5.7% (four cases) were complete failures and considered penicillin-resistant. Three of these four patients have apparently finally responded to sulfonamide drugs or recovered by means of body resistance alone, and the fourth is at present being observed and thus far has negative smears and cultures.

OTHER IMPRESSIONS

Additional information which may be of value and interest to those about to use this drug is set down in a more or less random fashion in the following paragraphs.

In the Group Three patients treated (seventy patients, 50,000 units penicillin first course) the urethral smears became negative in 24 hours and *remained that way* in forty-one patients (57.1%). In twenty-eight patients (41.4%) the smears became negative in twenty-four hours but *later again became positive* for gonococci (two of these later turned negative without further treatment), one patient (1.4%) did not respond to the penicillin at all. The time interval for those patients whose smears became negative to return to "positivity" varied from twenty-four hours to thirty-one days. There are three patients in whom the history suggested the urethral discharge had spontaneously recurred after seventy days, but inasmuch as the patients had left the military area during this interval, there was an element of doubt as to whether they should be considered as recurrences or reinfections. For this reason, they are not included in the above recurrences.

In the Third Group of patients, who received their penicillin in the 50,000 unit doses and finally a 200,000 unit course, there were in all 102 courses of treatment given. During the follow-up period of these patients, there arose on five occasions (4.9%) the situation wherein the patient was free of all signs and symptoms and yet urine cultures were found positive for the gonococcus. Had no cultural tests been made, these patients would have been considered as cured.

Six patients, who were apparently cured and who had been free of all urethral exudate for a minimum of twenty-one days and whose second glass of a two-glass urine test had been clear and who had had negative cultures on numerous occasions during these three weeks, developed positive urine cultures the day after sounding of the anterior urethra, or after gentle prostatic massage. These six cases represented a total of 8.5 per cent (figured on the basis of the original seventy patients) and may be considered as cases of hidden infections which were uncovered by these methods. Two patients developed what might possibly be considered as complications to these criteria of cure. One of them developed mild frequency the day following an anterior sounding on the 19th post-penicillin day. This responded to a five-day course of sulfathiazole and alkaline fluids. The second patient developed frequency also, and this followed prostatic massage of the gland, which the man doing the massage reported as moderately tender at the time of massage. It is felt that, if, since the gland had been deemed to have been tender, all further massage had been discontinued, the frequency would not have developed. There were no other symptoms such as fever, epididymitis or dysuria. The percentage of complications calculated on the basis of the original seventy patients was 2.8 per cent.

Three patients, not included in any of the above figures, were admitted to this hospital on different departments and were all interesting in that they demonstrated how the disease of gonorrhea may masquerade and the manner in which these unusual cases may be expected to respond to penicillin.

REPORTS OF CASES

CASE 1.—White male, age 26, admitted to the Orthopedic Service because of arthritic pains in the left shoulder and fingers. He gave no history of gonorrhea and the sedimentation rate was 41 mm. in an hour (Wintrone Method). The patient was afebrile and examination revealed nothing other than some wrist and finger joint redness and swelling. There was no urethral exudate. Urine cultures were performed and found to be positive for gonococci. Patient was then given 200,000 units of penicillin with alleviation of all symptoms and eventual return of sedimentation rate to normal. Many further cultures were negative for gonococci.

* * *

CASE 2.—White male, age 21, admitted to Surgical Service because of pain in the right lower quadrant of the abdomen. The primary diagnosis was appendicitis, but there was slight urinary frequency and dysuria which led to a urological consultation being requested. At this time an enlarged, tender right seminal vesicle was found and the consultant felt that this could be the cause of the symptoms. Patient denied any previous history of venereal disease or urethral discharge of any sort. Urine cultures eventually were positive for gonococci. Treatment with penicillin produced complete disappearance of the symptoms, which had previously already subsided somewhat due to bed rest, and resulted in all further urine cultures being negative for gonococci.

* * *

CASE 3.—Colored male, age 30, was attending the urological outpatient clinic because of pronounced lumbar backache. There were no symptoms other than these. No urethral discharge was present and two-glass urine test was clear. Prostatic examination revealed a chronic prostatitis. Patient gave a history of having been treated for gonorrhea 13 months previously but had had no urethral discharge or urinary symptoms since that time.

Urine cultures were positive for gonococci and the patient was treated with 100,000 units of penicillin. The urine cultures following this remained positive for gonococci and he was retreated with 200,000 units of penicillin and since this time, all cultures have been negative. Cultures on both the urine and prostatic secretion have been negative for gonococci. It was felt that the gonococci were located in a chronically infected prostate gland with poor blood supply and drainage and the unsatisfactory response to penicillin was traceable to this.

COMMENT

It was observed that while being treated the patients practically all retained a scanty morning urethral discharge for a period of 3-5 days. The results culturing this morning secretion varied as previously noted when discussing the three different groups of patients treated. It was found that a gram stain of the urine sediment was unsatisfactory as a method of following the patient's convalescence, and that the best means of noting patient's progres are: (1) to note the physical findings, such as urethral discharge or redness of the urethral meatus, (2) to note the results of two-glass urine test, and (3) morning urine cultures for gonococci. Eventual use of criteria of cure is a controversial point and depends much upon the ability of the practitioner. In general it may be said that if the doctor does not fully understand the pathology of gonorrhea and does not have considerable experience in prostatic massage and urethral sounding, these procedures are best left undone, as more harm than good may result. At present army regulations forbid their use except in the hands of recognized specialists and in specified hospitals.

Blood levels of penicillin were obtained in all patients treated and at varying intervals. The method of determining penicillin blood levels was based upon the ability of the dilutions of the patient's blood to inhibit the growth of Oxford staphylococcus aureous and streptococcus haemolyticus as compared with the ability of a series of standard penicillin solutions to do this. In all Three Groups of patients treated the blood level varied between .2 and .9 Oxford units. It was found that the blood level became markedly less during the third hour following penicillin injection. In all cases treated, the penicillin was given intramuscularly. It was felt, without too much proof, that limitation of fluids had aided in obtaining a satisfactory blood inhibition level.

Early in the use of penicillin, an attempt to correlate the efficiency of penicillin with the blood protein level was made. There proved to be no relationship whatsoever.

One patient, who received 100,000 units of penicillin, developed secondary syphilis six weeks later, demonstrating that the dosage of penicillin used in the treatment of gonorrhea is neither sufficient to cure nor to prevent syphilis. It is felt by many authors, however, that the dosage of penicillin used obscures the more dramatic manifestations of syphilis such as the chancre or secondary rash and that these patients quietly pass into the latent stage of syphilis. For this reason, it is recommended that serology tests for syphilis be performed at intervals of one month for a period of three months upon all patients who have received penicillin treatment for gonorrhea.

No complications whatever to penicillin were noted. Special note was taken during the latter half of the patients treated to inquire regarding the occurrence of any pain in the epididymus or testicles. No patient admitted to this.

Penicillin was given in both saline and water solutions, keeping the total dose given in most instances to 3 cc. Note was made as to the apparent degree of pain experienced and it was decided that the amount of pain experienced was practically equal with both solutions, but that possibly the saline preparation gave less discomfort. It was definitely noted that one particular "lot" of penicillin produced more pain than other lots. Less pain is experienced when the drug is placed deep in the muscle than in the subcutaneous tissue. All patients were maintained in the hospital 4-5 days but they were not kept on complete bed rest.

A certain number of reports have reached this department concerning the use of penicillin in non-specific urethritis and prostatitis and the drug has been tried in a few cases by the author. The results without exception have been poor and use of the drug in this type of patient is not recommended.

SUMMARY

1. Patient coöperation and hygienic living are still factors of prime importance in the treatment of gonorrhea even though penicillin is an efficient therapeutic agent.

2. The smallest effective initial dose of penicillin is 100,000 unts. Less than this will lead to a definite number of clinical failures and the occurrence of a certain number of penicillin-resistant patients.

3. A follow-up period of from thirty to sixty days is essential for all gonorrhea patients before they may safely be considered free of infection.

4. No patient can be considered cured unless repeated negative morning urine cultures have been obtained. These must be obtained in spite of the absence of all signs and symptoms of gonorrhea.

5. Patients with complicated or chronic gonorrhea should receive 200,000 units of penicillin, intramuscularly. A satisfactory method of administration is 20,000 units at two hour intervals for ten doses.

6. Penicillin has no value in the treatment of non-specific urethritis or prostatitis.

7. A certain number of cases which were resistant to sulfonamide drugs prior to receiving penicillin will respond to the sulfonamide drugs after a course of penicillin.

8. The initial satisfactory response of patients to penicillin does not pre-suppose eventual cure. Relapses may occur in from three to sixty days or longer.

10. On the basis of the above studies, satisfactory treatment for a non-complicated case of gonorrhea is 100,000 units of penicillin administered in 20,000 unit doses intramuscularly at two hour intervals. The patient should then be checked at three day intervals, at which time physical examination of the genitalia will be performed, two-glass urine tests taken, and urine cultures obtained. Eventually, after the second glass of a two-glass urine test has been clear for a period of three weeks, he may have prostatic massage and urethral soundings followed by more urine cultures. The latter are best performed alternately and with rest periods of three days between treatments. Two of each procedures should be considered as minimum.

March Field.

The public health and social benefits resulting from the hospitalization of infectious cases of tuberculosis are not sufficiently recognized. These social benefits need greater emphasis and the question of the individual's ability to pay should be subordinated to the more fundamental consideration of the public welfare.—Robert E. Plunkett, M.D., N. Y. State Dept. of Health, *Annual Report,* 1942.

"Progress comes from ideas that establish new assumptions from which reason and analysis must spring. Research is the stabilizing influence in this cycle, since it carries on knowledge to new points."—*William B. Stout.*

PRENATAL BLOOD TESTS and CONGENITAL SYPHILIS*

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THE prenatal blood test law became effective in California on September 19, 1939. This made California the fourth State to pass such legislation for control and eradication of congenital syphilis.

On theoretical grounds, the effective enforcement of such a public health procedure should materially reduce newborn congenital syphilis and eventually stamp it out. With a view to partially evaluating this law, the present survey was undertaken. The procedure was as follows:

All congenital syphilis reports to the Los Angeles City Health Department in births occurring subsequent to the passage of the prenatal blood test law were collected. A questionnaire was prepared and personal contact made with each mother to gather certain facts.

CLINICAL MATERIAL

The study covers congenital syphilis cases whose births occurred between February 6, 1940 and March 10, 1944. Only 30 proven and completed cases could be written up for this period, although more were reported. In some instances, the whereabouts of the mother or father could not be obtained. In general, the coöperation of mothers interviewed was good, and their answers dependable.

Statistical tables condensing the information from which conclusions have been drawn are submitted.

TABLE 1.[1]—*Racial Distribution of Total Births in Los Angeles City, and 30 Congenital Syphilis Births*

Race	Total Births	Congenital Syphilis Births
White	89,061	7
Mexican	13,376	8
Colored	5,692	14
Unknown		1
	108,129	30 Cases

Table 1 shows that the proportion of congenital syphilis births among Mexicans and Negroes is much higher than among the white population. According to the November, 1944, *Monthly Report of the Bureau of Venereal Diseases* of the California State Health Department "an alarming increase of over 50 per cent congenital syphilis cases among the Negroes" has occurred. Table 2 supports this inference.

The State Health Department figures also show a marked decrease in reported congenital syphilis cases in the under one and the one to four year age groups. This occurred in spite of a war time increase of 54.8 per cent in the number of births from 1940 to 1943.

TABLE 3.[2]—*Number of Cases of Congenital Syphilis Reported in California by Age Groups 1940-1943*

Births	Year	Age Less Than One Year		Age One to Four Years	
		No.	%	No.	%
111,000	1940	136	.12%	77	.06%
125,000	1941	93	.07	59	.04
153,000	1942	74	.04	53	.03
173,000	1943	74	.04	63	.03
562,000		377	.06	252	.04

The State Report (Table 3) shows a 50 per cent decrease in the per cent of congenital syphilis cases in the under one year age group and a 24.7 per cent decrease in the one to four age group, "indicating that since the law was in effect many more pregnant women with syphilis are being treated."[2]

TABLE 4.[1]—*Age of Mother at Time Baby Born*

Ages	Number
15 through 17	3
18 through 20	6
21 through 23	10
24 through 26	6
27 through 29	2
30 through 35	0
36 through 38	1
Age 41	1
Unknown	1
TOTAL	30 Cases

In Table 4 it is seen that almost two-thirds of the births occurred to mothers under the age of 24 years.

TABLE 5.—*Time Interval Woman Considered Herself Pregnant Before She Went to Doctor*

Months Pregnant	Number
Less than 1 month	8
1 to 2 months	2
2 to 3 months	2
3 to 4 months	3
4 to 5 months	3
5 to 6 months	1
6 to 7 months	3
7 to 8 months	2
Over 8 months	1
At time of labor	3
Unknown	2
TOTAL	30 Cases

Table 5 shows that 50 per cent of the expectant mothers went to a physician before the fourth month of pregnancy, a time when prompt treatment of diagnosed syphilis could, in most cases, result in the birth of a nonluetic child.

TABLE 6.—*Time at which Blood was Taken for Test*

First visit	17
Second visit	1
2 months after first visit	2
Not taken	10
TOTAL	30 Cases

TABLE 2.[2]—*Number and Per Cent of Cases of Congenital Syphilis Reported in California by Race, 1940-1943*

Race					Per Cent			
	1940	1941	1942	1943	1940	1941	1942	1943
White	318	458	413	567	35.1	55.3	57.5	57.2
Negro	83	95	107	203	9.2	11.4	14.9	20.5
Mexican	155	180	142	177	17.1	21.7	19.7	17.9
Other	34	56	36	18	3.8	6.7	5.0	1.8
Unknown	315	41	21	26	34.8	4.9	2.9	2.6
Total	905	830	719	991	100.0	100.0	100.0	100.0

* From the offices of the Health Officer and Epidemiologist of the City of Los Angeles.

Acknowledgment.—The authors are indebted to H. C. Pulley, M.D., Chief Assistant Health Officer, for his constructive criticism and timely suggestions.

Seventeen of the thirty luetic mothers had a blood test at the first visit to the doctor. It is unfortunate that one-third of the thirty had no blood test during pregnancy. These two tables show that half the mothers went to a doctor before the fourth month and over half had a blood test at the first visit.

TABLE 7.—*Interval from Time of Blood Test to Beginning of Treatment*

As soon as report back	9
At time of chancre (early tests negative)	1
One month	1
Two months (early tests negative)	1
Not notified of result—no treatment	4
Told it was negative—no treatment	3
Unknown	1
No blood test in pregnancy	10
TOTAL	30 Cases

COMMENT

In four instances, blood tests were made but the patients were not notified of the result, and hence no treatment was given during pregnancy. Table 7.

* * *

In one patient blood was taken by a private doctor at the first visit, two months after the woman considered herself pregnant. This visit was in July, 1943. She did not return to her original doctor, but went to one of the Los Angeles City Health Department clinics where five consecutive blood tests were negative and the sixth was positive. Treatment was started two weeks after the last test, on September 23, 1943. Prior to her baby's birth on January 18, 1944, she had twelve bismuth and seven arsenical injections.

* * *

In another patient a blood test performed in the third month of pregnancy was negative. In December, 1940 (about the eighth month) the woman presented herself at the Los Angeles City Maternity Clinic with a vulval lesion which was darkfield positive. Blood test at this time was also negative. Only three arsenical and bismuth injections could be given before the birth of a luetic baby on January 6, 1941. This same patient had three other children, the first two born prior to the birth of the luetic child and one following. Two children, ages 6 and 4, were both found to be negative by examination and blood test. The third child, born February 21, 1942, or more than 13 months following the birth of the luetic child also has congenital syphilis. The reason the mother gave for her failure to take regular treatments was that she had no funds for carfare to attend the clinic. This case demonstrates the births of two consecutive congenital luetic children to one mother, the first closely following a primary lesion in the mother; the second due to inadequate maternal anti-luetic therapy in the thirteen months interval between the births.

* * *

The mother of one congenital luetic child, which was born on February 8, 1944, had two other children, age 3 and 2, both well. Her husband entered the Army in December, 1942, and was stationed in another city. In February, 1943, she had a blood test for a defense job which was negative. On March 6, 1943, she visited her husband in training. On April 25, 1943, she had another blood test and was told it was positive. She took four "arm treatments," then left for another city without her husband, but did not resume treatment there until October, 1943. She arrived in Los Angeles in January, 1944, after taking a total of sixteen arm injections. No further treatments were taken before the baby's birth on February 8, 1944. The child was luetic.

* * *

Six congenital luetic children of the thirty were born out of wedlock. Five were not born in California, and hence could not have been protected by our prenatal blood test law. Of these five, two were born in Arkansas at home, one in Utah en route to California, one in Mexico City and one in Albuquerque.

Ten mothers gave a history of previous pregnancies resulting in non-luetic children (Table 8):

TABLE 8.

Number of Mothers	Previous-Non-luetic Children
3	1
4	2
1	3
1	4
1	10

Table 8 effectively emphasizes that previous pregnancies do not necessarily protect against the birth of a luetic child and should not influence against the taking of blood tests in each pregnancy.

Five mothers had one normal healthy child following the birth of a luetic child. In these cases adequate anti-luetic treatment was given the mother during her subsequent pregnancy.

In two instances two consecutive congenital luetic children were born to a luetic mother.

Three patients had been previously diagnosed and treated for syphilis, yet this did not prevent the subsequent birth of a luetic child. One patient took treatment originally two years previously, came to California before she was "cured," and failed to resume treatment. Another patient was diagnosed and treated in 1938, four years previously, but had no treatment for the current pregnancy. One patient had five hip treatments in 1941, and although she received follow-up cards, failed to continue treatment. Her luetic child was born September 20, 1942.

These three cases demonstrate the importance of resuming anti-luetic treatment on the expectant mother who has been diagnosed, "acquired syphilis," regardless of the type or amount of therapy previously received.

TABLE 9.—*Amount of Treatment during Pregnancy in Mothers Who Bore a Syphilitic Child*

Case Number	Diagnosis Made	"Arm Treatment"	"Hip Treatment"	Months of Treatment	Baby Born
5	9- 1-43	6 (Mapharsen each .04 gm)	5 (each .15 gm. Bismuth)	5	2- 4-44
9	9- 1-43	7	12	4.5	1-18-44
12	6- 1-43	12	12	3.3	9-10-43
13	12-28-40	3	3	0.3	1- 6-41
23	5- 1-42	0	5	4.5	9-20-42
25	3- 8-42	4 (Arsenicals)	0	2.0	5- 7-42
27	8- 3-41	10 (Arsenicals each .45 gm)	10	5.2	1-10-42
28	10- 1-43	16	0	4.2	2- 8-44

CONCERNING TREATMENT

Table 9 shows the amount of treatment given in pregnancy which failed to prevent congenital syphilis. Apology is made for the absence of more detailed data on dosage, but this information was not obtainable.

Case 5 had five bismuth injections, each .15 gram, and six mapharsen injections each .04 gram just prior to the child's birth. Case 9 had twelve hip and seven arm injections during the fifteen weeks prior to delivery, type of drug and dosage are not known. Case 12 started antiluetic treatment in the middle of June, 1943, taking one arsenical and bismuth injection weekly until the baby's birth on September 10, 1943, three months later. Case 13 received only three arsenical and bismuth injections before delivery. Case 18 started treatment on September 13, 1940, about seven months before delivery. Other than the fact that "regular treatment" was given, nothing further could be elicited from the private doctor. Case 25 had one month of arsenical therapy, dose unknown, before delivery. Case 27 had ten weekly bismuth treatments, followed by ten weekly arsenicals (each .45 gram) up to the time of delivery. Her treatment was started in the fourth month of gestation. Case 28 had sixteen "arm" injections.

TABLE 10.—*Facts Pertaining to the Father*

a. Father diagnosed and under treatment	12
b. Father examined and not diagnosed syphilis	7
c. Father examined, diagnosed but not treated	1
d. Father in Army, treatment status unknown	2
e. Father's whereabout unknown	4
f. Father not examined, reason unknown	4
TOTAL	30 Cases

The information given in Table 11 was obtained, relative to mother and luetic child, of medical care subsequent to the diagnosis of congenital syphilis.

TABLE 11.—*Treatment Status of Mother and Child Subsequent to Birth of Syphilitic Child*

	Mother	Child
a. Still under active treatment	23	18
b. Under medical supervision	4	5
c. Refused treatment	2	..
d. Not under treatment	..	5
e. Died	..	2
f. Unknown	1	..
TOTAL	30	30

Parents were uncoöperative in four of the five instances where the child was not receiving treatment. In the fifth case the mother stated she was going to take the child to a clinic.

SUMMARY

Thirty cases of congenital syphilis subsequent to the passage of the prenatal blood test law in California are presented.

Congenital syphilis is higher among Negroes and Mexicans than among the white population of Los Angeles.

Fifty per cent of these luetic mothers went to a physician before the fourth month of pregnancy, at a time when prompt and adequate treatment presumably could have resulted in a non-luetic child.

Although the majority of mothers had a blood test at the first visit to the doctor, one-third had no such test during pregnancy.

One case had a negative blood test early in pregnancy (third month) and a primary vulval darkfield positive lesion the eighth month.

Two mothers gave birth to two consecutive congenital luetic children.

Five of the mothers continued to receive adequate anti-luetic therapy following delivery. Subsequently, each one became pregnant, and each was delivered of a non-luetic baby.

Some of the mothers were uncoöperative in receiving adequate therapy during pregnancy.

One-third of the mothers had previously given birth to non-luetic children.

Three of the thirty mothers had been previously diagnosed as syphilitic and had had previous treatment, which, however, was inadequate.

CONCLUSIONS

Although this survey is numerically small, it does stimulate the following thoughts:

1. A blood test should be done at the first visit in pregnancy and once again before delivery.
2. Syphilitic women should receive adequate therapy in each pregnancy.
3. A more active follow-up program for the treatment of the luetic parturient is indicated.
4. California falls heir to congenital luetic births among recent arrivals from states which have no prenatal blood test law.
5. Early and adequate prenatal care and willingness of patients to coöperate in the enforcement of the intent of the law will materially reduce the incidence of prenatal syphilis.

116 Temple Street.

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ARTERIOSCLEROTIC GANGRENE WITH SPECIAL REFERENCE TO AMPUTATIONS BELOW THE KNEE*

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THE material forming the basis of this study is taken from a series of 107 cases treated at the Los Angeles County Hospital from January 1, 1942, to July 1, 1944. Gangrene of the dry or wet type was the presenting complication in all instances, and the causative factor was an underlying arteriosclerosis obliterans. Diabetes mellitus was an associated factor in 99 instances, while the remainder were purely of the senile gangrene type. Responsibility in the care of these patients was divided between the Medical and the Orthopedic departments, but our discussion here will be limited to the surgical phases of the problem. Major amputations were performed in 60 limbs as shown in Table 1.

TABLE 1.—*107 Cases of Arteriosclerotic Gangrene, With and Without Diabetes Mellitus.*

Type of Management Received:	No. Cases
1. Medical Régimé (Buerger-Allen Exercises, Physiotherapy, Hot Packs, Paravertebral Blocks, Sulfa Therapy, Heat Cradles, etc.)	22
2. Incision and Drainage	8
3. Toe Amputations	7
4. Supracondylar Amputations, Closed Method	23
5. Supracondylar Amputations Open Method	1
6. Below-the-knee Amputations, Closed Method	34
7. Below-the-knee Amputations, Open Method	2
8. Peripheral Nerve Crushing	1
9. Skin Grafts	2
10. Treatment Refused by Patient	7
TOTAL	107

* From the University of Southern California Medical School, Department of Orthopedic Surgery.



Fig. 1.—The skin flaps are outlined with methylene-blue. Patient on abdomen and knee flexed. No tourniquet is used.

The decision to amputate was not contingent upon any special tests such as the histamin flare or the occelometer, but rather upon clinical grounds alone. A history carefully taken with respect to peripheral vascular symptoms and a detailed examination of the part will suffice to determine both the necessity for, and the level of, a major amputation. We are of the opinion that below-the-knee amputations are to be encouraged, and as our technique improves, we find that greater successes may be expected. At the present time we are doing all our major amputations below the knee, excepting when the following criteria obtain:



Fig. 2.—The skin and subcutaneous fat are cut to bone in front and to deep fascia behind. The amputation knife touches the front edge of both bones.

1. When there are no pulsations felt in the femoral arteries.
2. When cellulitis is spreading or gangrene is present above the lower one-third of the leg.

TECHNIQUE OF BELOW-THE-KNEE AMPUTATIONS

On coming to surgery the patient is given both a spinal anesthetic and a lumbar paravertebral block. Six cc. of an oily solution of procaine hydrochloride is deposited opposite the second, third, and fourth sympathetic ganglia.

Figure 1 illustrates skin flaps outlined and the leg draped, with the patient on his abdomen. No tourniquet is used. The first cut is made down to the fascia behind, and through the periosteum in front. In order to expose the large vessels, we find it helpful to first cut away the bulk of the overlying muscles. To accomplish this the knife is entered just behind the fibula at the "jaw" of



Fig. 3.—The knife edge is turned and by a sawing motion the muscle mass is cut without damage to the deep vascular structures. By the same procedure the posterior vessels are approached.



Fig. 4.—One plaster roll forms the overshell. Immobilization promotes healing. Gravitational tug on the suture line is prevented.

TABLE 2.—*Results in 34 Below-the-knee Amputations.*

	Number of Cases	Primary Healing	Complicated Healing		
				Failures	
			Hospital Stay Prolonged But No Further Surgery Required	Reamputated Below the Knee	Reamputated Above the Knee
Those receiving paravertebral blocks.....	24	18	2	1	3
		75%	8.3%	4.1%	12%
Those *not* receiving paravertebral blocks.	9	6	2	1	
		66.6%	22.2%	1.2%	0
Those receiving peri-arterial strippings..	1	1	0	0	0
Totals (cases)	34	25	4	2	3

the skin flap, and exit is made 1 cm. posterior to the back of the tibia. The cut is then completed, following along the skin edges to fashion the muscle flap. This routine is then repeated in the anterior group, but here the entrance can be made in front of the fibula and the exit in front of and adjacent to the tibia without endangering the anterior tibial vessels. (Figs. 2 and 3.) The artery can be felt in the uncut portion of the musculature and ligated with appropriate sutures. The muscle remaining between the bones is severed and all the soft tissue is stripped toward the knee far enough to insure a loose flap. A beveled cut on the tibia and a resection of the fibula one inch higher are done in the conventional manner. No fascial sutures are used. Interrupted fine cotton sutures are placed in the skin 1 cm. apart and a fluffy dressing is applied, then covered with sheet wadding. One eight-inch roller bandage of plaster-of-Paris is applied with the knee in slight flexion. (Fig. 4.)

POSTOPERATIVE CARE

Paravertebral blocks are repeated on the third, sixth, and ninth postoperative days, and the sutures are removed, together with the cast, on the tenth. An ACE bandage is then applied to promote shrinking.

In Table 2 the results are summarized and they indicate the value of the paravertebral block routine as an adjunct in postoperative care. Those cases in which no block was given received similar treatment otherwise. Twenty-four cases receiving blocks went on to primary uncomplicated healing in 18 instances, or 75 per cent, while 9 cases not receiving the blocks healed per primum in 6 instances, or 66.6 per cent. One case of primary healing was subjected to a peri-arterial stripping of the femoral artery in the adductor canal at the time of amputation; this case was the first in which any attempt on our part was made to interrupt vasospastic tone.

Of the 34 cases amputated below the knee, there were 5 failures, or 14.7 per cent. Two of these showed no evidence of pulsations in the femoral arteries, and one of these two was so badly involved in the arteriosclerotic process that neither brachial nor radial pulsations were felt. A third failure was due to a spreading cellulitis above the lower one-third of the leg.

DISCUSSION

It has long been known that trauma to an extremity is followed by an immediate and sometimes prolonged vasospasm by a reflex action along sensory pathways. The trauma of amputation itself incites vasospasm by severely stimulating these pathways. While a single block of the sympathetic chain may permanently break the vasospastic reflex, we are of the opinion that it will not in most instances. Upon this supposition, therefore, we have followed the original block with others repeated throughout the healing period.

CONCLUSIONS

1. Below-the-knee amputations in arteriosclerosis obliterans are both feasible and safe if femoral pulsations are present and if cellulitis does not extend above the lower one-third of the leg.
2. Paravertebral blocks at the time of amputation and continued throughout the healing period increase the incidence of primary healing by releasing reflex vasospasm in the skin flaps.
3. Atraumatic technique, avoidance of tourniquets, and immobilization of the stump in a plaster shell are mentioned only to reëmphasize principles previously laid down by others.

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PRIMARY CANCER OF THE LUNG*

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IN recent years the medical literature has contained many articles on cancer of the lung. The clinical, pathological and therapeutic aspects of the disease have been analysed and critically evaluated.[1,2,3] Much light has been thrown on the clinical features of this condition. In spite of this, the disease is taking an annual toll of 15,000 lives and is increasing in frequency.[4,5] The matter certainly deserves serious attention.

It appeared justifiable to appraise the local status of this disease by reviewing a group of patients. It was also hoped that the data elicited might contribute toward earlier diagnosis. Hence this paper records clinical and pathological data on 50 consecutive cases of bronchogenic carcinoma from the San Francisco City and County Hospital. In all of the cases the diagnosis was either confirmed or established at autopsy.

CLINICAL DATA

Age, Sex and Occupation: The ages of the patients ranged from 28 to 81, the average age being 55 years. The majority of the patients fell into the 5th, 6th and 7th decades of life. Forty-five were males and 5 were females. There was an exposure to dust or other irritating substances in 16 individuals of the group. The wide variety of occupations of the afflicted personnel is illustrated in Table 1.

Preëntry Medical Advice: In 28 of the cases a physician had been consulted before the patient entered the

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TABLE 1.—*Occupational Incidence.*

Packer	3	Merchant	1
Housewife	2	Laborer	9
Musician	2	Janitor	3
Cook	2	Carpenter	2
Hotelman	1	Longshoreman	1
Timekeeper	1	Auto Painter	1
Fruit Peddler	1	Roof Worker	1
Orderly	1	Painter	1
Butcher	1	Coal Miner	1
Seamstress	1	Brick Layer	1
Rancher	1	Garbageman	1
Bottlewasher	1	Cement Worker	1
Kitchen Helper	1	Truck Driver	1
Salesman	1	Iron Molder	1
Garment Cutter	1	Auto Polisher	1
Porter	1	Unrecorded	3

hospital. Primary carcinoma of the lung was diagnosed in only 3 instances although in 11 other cases pulmonary disease was suspected.

Symptoms: At the time of admission the majority of patients complained of a number of symptoms. These included a productive cough, pain in the chest, dyspnoea, hemoptysis, wheezing, loss of weight, weakness and anorexia. The incidence of the various symptoms is shown in Table 2.

TABLE 2.—*Symptoms on Admission.*

Symptoms	Cases
Loss of weight	36
Pain in Chest	31
Dyspnoea	30
Productive Cough	27
Weakness	27
Hemoptysis	25
Wheezing	21
Anorexia	17
Persistent "colds"	13
Noctridrosis	13
Non-productive Cough	12
Pain in Back	12
Abdominal Pain	10
Nausea and Vomiting	9
Fever	5
Hoarseness	4
Visual Disturbances	3

A careful study of the symptomatology was made in an attempt to throw light on the evolution of the disease. The disease usually began with a dry, irritative cough that became persistent. It was often considered to be a cigarette cough. As the condition progressed the cough gradually became productive of watery, mucoid sputum. Later, the sputum thickened and was mucopurulent or purulent. In some cases it was copious in amount and foul in character. Not infrequently it was streaked with blood or was frankly bloody. Hemoptysis occurred in one-half of the patients.

An appreciable number of the patients dated the onset of their illness from a "cold" with productive cough from the beginning. Only 10 patients denied having had a cough early in the course of their illness.

As the disease progressed the patients experienced wheezing, dyspnoea and pain in the chest. The latter was often severe. Anorexia and fever occurred and were followed by loss of weight and weakness. Symptoms referable to other parts of the body, e.g., pain in the back, headache, abdominal pain, dysphagia, hoarseness, visual disturbances, mental confusion and urinary symptoms occurred variously in members of the group. These symptoms were explained later partly on the basis of metastasis and partly as a result of pressure by masses of tumor on vital structures. In 5 members of the group there were no complaints directly referable to the chest.

The duration of symptoms averages 11.5 months. Thirteen patients entered the hospital with symptoms of less than 3 months duration; more than forty patients claimed they had symptoms for less than a year. Death occurred usually within 3 months after entrance to the hospital.

Physical Findings: Physical findings in the chest depended in a great part upon bronchial obstruction and the degree of secondary change that had occurred in the lungs and pleura. These included restricted expansion and changes in the precussion note, breath and voice sounds as well as rales and rhonchi or wheezes. Signs due to metastasis were also variable depending upon the site and degree of involvement.

Diagnosis: In the series of 50 cases, a diagnosis of bronchogenic carcinoma was either made or considered in 22 patients on admission to the hospital. At this time, 11 patients were thought to have pulmonary tuberculosis, 2 were thought to have pneumonia and 6 an undetermined mediastinal mass. In 6 patients the clinical impression was based entirely on metastatic involvement. Abscess of the lung was mentioned only once as an entry diagnosis. The diagnosis of bronchogenic carcinoma was not made until autopsy in 19 patients in this series. In one patient a diagnosis was made by means of exploratory thoracotomy. In the remaining 30 patients the diagnosis was established by clinical, roentgenographic and bronchoscopic study.

Treatment: The majority of patients had far advanced disease with metastases on entry to the hospital. Hence, treatment was mainly palliative. X-ray therapy was used in eight patients. In one case a total pneumonectomy was done and in another a metastatic tumor of the frontal lobe was removed.

PATHOLOGICAL DATA

Location of Tumor: The primary lesion was found at the carina in 3 instances, in the main bronchi in 34 patients and in lower order bronchi in 13 patients. It occurred slightly more often on the right side than on the left.

Histological Type: There were 10 squamous cell carcinomas, 11 adenocarcinomas, and 29 of the undifferentiated type.

Secondary pulmonary changes included abscesses, atelectasis and emphysema. Co-existing tuberculosis was found in 3 patients. Metastases from the primary lesion occurred in 39 patients. There were secondary lesions found in regional lymph nodes, the lungs and pleura, in the liver, adrenals, kidneys, bone and brain. The squamous cell tumors showed less tendency to disseminate than the other types as shown in Table 3.

TABLE 3.—*Incidence of Metastasis and Local Invasion.*

Organ	11 cases Adenoca.	29 cases Undiff.	10 cases Squamous	Total
Liver	10	11	2	23
Adrenals	5	14	2	21
Bronchial Nodes	4	14	3	21
Mediastinal Nodes	4	10	2	16
Other Lung	3	7	3	13
Thoracic Cage	5	4	2	11
Pleura	2	7	1	10
Kidneys	3	7	0	10
Brain	1	6	0	7
Heart	0	6	1	7
Vertebral Column	1	6	0	7
Same Lung	1	3	3	7
Tracheocervical Nodes	2	3	0	5
Abdominal Nodes	2	2	0	4
Thyroid	1	3	0	4
Vessels	0	4	0	4
Pericardium	1	0	2	3

DISCUSSION

The foregoing study shows unmistakeably that there is a definite lag between the present knowledge of cancer of the lung and its application in practice. Although the series is small, it is representative of the failure to diagnose the disease except in its terminal phases.[6]

Perhaps the most regrettable aspect of late diagnosis is that today thoracic surgeons are able to remove suc-

cessfully the diseased lung. The importance of early diagnosis especially before metastases[7] have occurred clearly indicates the opportunity for cure. More and more 5 year cures following pneumonectomy of the cancerous lung are being reported (Overholt).[8]

Obviously, attention must be sharply focussed on the early diagnosis of this lesion.[9] Perhaps the most important single factor in its diagnosis is that physicians think of the possibility of bronchogenic carcinoma. As shown in the present study the earliest clinical evidence in a majority of cases is persistent cough, dry at first, later productive. The sputum may or may not contain blood. Wheezing, dyspnoea, pain in the chest and hemoptysis commonly occur. The above evidences should at once suggest the possibility of the disease, particularly if they occur in the male sex after age 40.

It was of interest in this series that relatively few abscesses were found as the presenting symptom of the carcinoma. There was also a relatively low percentage of involved cervical lymph nodes.

The occurrence of any or several of these symptoms should not only arouse suspicion in the physician's mind but should compel him to make a complete clinical examination including an x-ray of the chest. Regardless of the outcome of the examination, if the symptoms persist, the patient should be bronchoscoped. The present study, in accordance with the literature,[2,5,10] shows that the majority of bronchogenic neoplasms arise in the main bronchi, thus being easily visualized by endsocopic examination. It is true that some of the lesions occur in lobar or smaller bronchi and may not be seen through the bronchoscope. In such cases however, the roentgenogram often reveals the tumor. In some instances, exploratory thoracotomy may be necessary. One thing is certain, vigorous prosecution of diagnostic measures will reveal the identity of the lesion in the majority of patients.

SUMMARY

A clinical and pathological study of 50 cases of primary carcinoma of the lung is reported. It was found that the diagnosis was usually made in the late or terminal stages of the disease. Clinical data leading to an earlier diagnosis is outlined.

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Lanfranc of Milan (d. 1316) describes thirty-two forms of ulcers in his *"Chirurgia Magna"* and *"Minor."*

Roland of Parma, who flourished in 1250 and who was the pupil of Roger, advocated the excision of chancres.

EDEMA OF THE EYELIDS IN TRICHINOSIS*

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Introduction.—Recent studies and a review of the literature[12,13,19,20,22,24,25,27,33] reveal the fact that approximately twenty per cent of the general population are infected with trichinae. It appears also that very little effort has been made to determine the basis of one of the conspicuous symptoms of trichinosis, namely, edema of the eyelids. It is because of this fact that the following study was undertaken. The autopsy findings in two of the eleven unselected patients included in this study are of special interest since their extra-ocular muscles were found to be heavily infested with both calcified cysts and live-worm forms of Trichinella spiralis.

METHOD

The material studied was obtained from autopsies upon the bodies of eleven unselected patients. In each instance, the extra-ocular muscles were removed and examined by pressing small pieces of each rectus muscle between heavy plate glass and looking for trichinae with a dissecting microscope. Also, whenever possible, approximately 50 grams of the following muscles were removed from the same body, namely, laryngeal, deltoid, sternocleidomastoid, pectoralis major, diaphragm, rectus abdominis and gastrocnemius. The digestion technique was employed in searching for trichinae in these muscles.

DISCUSSION

Tiedman,[2,21] in 1882, was probably the first to observe Trichinella spiralis in human muscle, but R. Owen gave the parasite its present name some fourteen years later. It was not until 1860 that Zenker[2] disproved the commonly held views, both that trichinellae were harmless hosts of man and that they were larval forms of either "Strongylus" or "Trichocephalus," as was believed by such eminent men as Virchow and Kückermiester. Shortly afterward, he demonstrated the cycle of development of Trichinella spiralis. Another great contribution of fact concerning this disease was made by Herrick and Janeway[15] in 1909 when they first demonstrated the parasite in the circulating blood of man.

In the study reported here, trichinae were found in the extraocular muscles from two of the eleven unselected bodies investigated and also in the skeletal muscles removed from four bodies exclusive of the extra-ocular muscles. A review of the literature reveals that very few investigators have actually found trichinae in the extra-ocular muscles. Von Herrenschwand[32] reported such a finding in one body in 1927, which he illustrated. Fuchs[11] also illustrated a case in 1927. Another illustration of trichinae in the extra-ocular muscles is found in Friedenwald's[10] text published in 1929. The statement[10,16] that "Edema of the eyelids is due to an infestation of the extra-ocular muscles with trichinae." is made frequently. However, we have been able to find the records of only three instances in which trichinae have been demonstrated in these muscles. It is true that a muscle infested with trichinae is accompanied by edema, and that edema of the eyelids could result from infestation of the extra-ocular muscles with trichinae, but it does not follow that edema of various tissues, such as

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TABLE 1.—*Trichina Findings. Eleven Patients.*

Patient	Age	Sex	Race	Trichina in Muscles								Cause of Death (Autopsy)	Remarks
				Extra-Ocular	Laryngeal	Sternocleidomastoid	Deltoid	Pectoralis Major	Rect. Abdominis	Diaphragm	Gastrocnemius		
1	78	M	C	326†	100+†	25†		200+†	100+†	700+†	25†	Coronary Sclerosis; congestive heart failure; carcinoma of hand.	Artist. For years had occasional twitching of lids.
2	70	M	C	0	0	0	0	0	0	1†	0	Richter's Hernia with intestinal obstruction; pre-renal azotemia; bronchopneumonia.	
3	74	M	C	0	0	0	0	0	0	0	0	Bronchopneumonia.	
4	64	M	C	0	0	0	0	0	0	0	0	Tuberculosis, Pericarditis, Pneumonokoniosis.	
5	73	M	C	0	2*	10*		40*	11*	50*		Coronary Occlusion.	No History.
6	67	M	C	195† 5–10 live worms and calcified cysts per each sq. 185* cm. surface of all these muscles.								Carcinoma Bladder with Ureteral Obstruction. Pyeponephritis. Uremia.	Occupation—Butcher for 10 years before death.
7	73	M	C	0	0	0	0		0	0	0	Pulmonary Tuberculosis.	
8	72	M	C	0	0	0	0	0	1*	0	0	Lobar Pneumonia. Suppurative Pleurisy. General Arterio Sclerosis. Severe Myocardial damage.	
9	38	M	C	0	0	0	0	0	0	0	0	Perforated peptic ulcer. General Peritonitis; Chronic Alcoholism with Delirium.	
10	68	M	C	0	0	0	0	0	0	10*	0	Ureteral Stricture with Urinary Extravasation. Bronchopneumonia. Carcinoma mouth.	
11	68	M	C	0	0	0	0	0	0	0	0	Hypertensive Arteriosclerotic Heart Disease.	

* Live worms.
† Calcified cysts.
Note: Patient No. 6:—The autopsy was limited so that only the extra-ocular muscles were removed. Biopsy was used to confirm the gross findings.

the eyelids, is always accompanied by trichinae in the edematous structure. What is not known at present is whether or not edema of the eyelids occurs in patients who have trichinosis and who do not have infestation of the extra-ocular muscles. It must also be realized that edema of the eyelids, as it occurs in patients who have trichinosis, may be a local non-specific manifestation of toxemia which results from a generalized invasion of the body exclusive of the extra-ocular muscles, and that in those patients who have infestation of the extra-ocular muscles the edema of the eyelids is merely incidental. Supporting this view are the numerous observa-

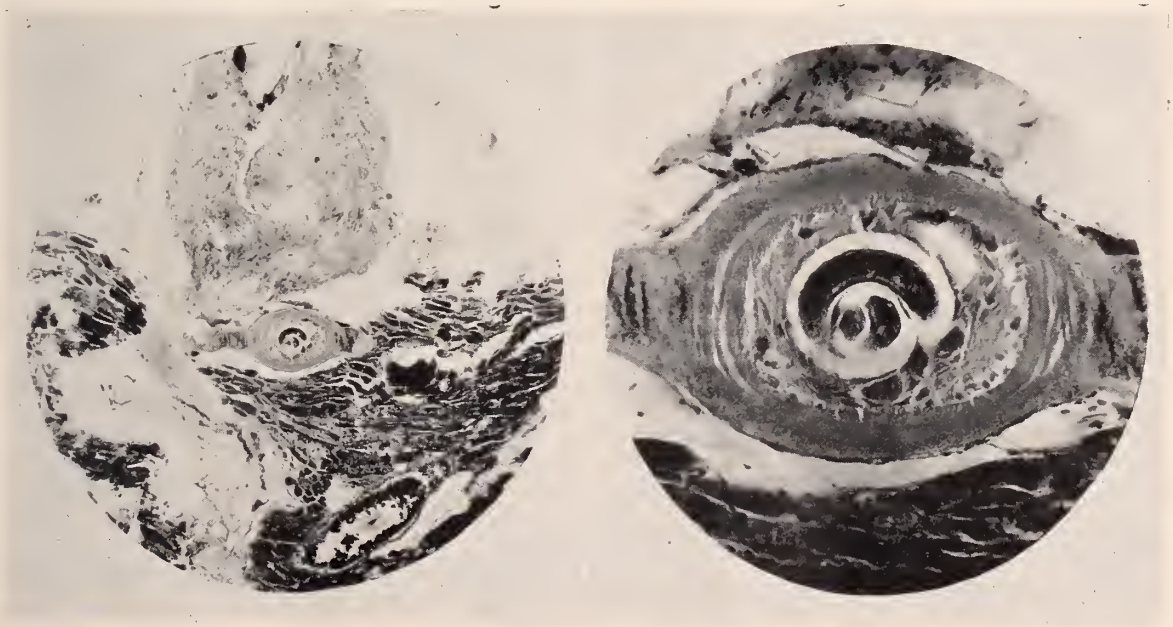


Fig. 1.—Low Power Trichina Work Encysted in Extra-Ocular Muscle. Patient No. 6. High Power of Same.

tions[4,8,9,14,18,23,29,30,31] found at autopsy in patients dying of trichinosis, reporting pathological evidence of toxic changes in the kidneys, heart, meninges, and brain, in which organs no trichinae were found. These toxic changes are therefore a non-specific manifestation because they occur in tissue in which no trichinae are present. As these non-specific toxic changes do occur in the above tissue, it is reasonable to believe that they could also occur in the tissues around the eyes and thereby serve as the basis by which to explain edema of the eyelids, rather than the commonly held view that the edema is due to the presence of trichinae in the extra-ocular muscles. This view would be proved if it could be demonstrated that edema of the eyelids occurred in proven cases of trichinosis in which no trichinae were found at autopsy in the extra-ocular muscles or in the tissues around the eyes, and if no other causes of the edema could be demonstrated.

It appears that the cause of edema of the eyelid in patients who have trichinosis has not been satisfactorily explained.

In the study reported here, two patients who had trichinosis were found to have the extra-ocular and other skeletal muscles heavily infested with trichinae. In none of these patients was edema of the eyelids observed before death, according to their hospital records. In six of the eleven bodies studied trichinae were demonstrated. Undoubtedly,[3] less discrimination is practiced among this group of charity patients in the selection and preparation of their diet than is practiced by the population at large, which factor may help explain the high incidence. However, this group is too small from which to draw any conclusion regarding a true incidence.

CONCLUSIONS

1. The commonly held view that "edema of the eyelids in trichinosis is due to the presence of trichinae in the extra-ocular muscles" lacks sufficient supportive evidence to date and must therefore be considered an assumption.

2. The concept is advanced that the edema of the eyelids as it occurs in trichinosis may be principally a non-specific toxic manifestation and not entirely due to the presence of trichinae in the extra-ocular muscles or tissues around the eyes.

3. Two instances of extra-ocular-muscle trichinosis occurring in the eleven unselected patients investigated are reported and illustrated.

4. Trichinae were demonstrated in six of the eleven bodies studied.

5. In none of these patients had there been recorded clinical symptoms of trichinosis.

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PSYCHIATRIC CASUALTIES*

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San Francisco

THE large percentage of psychiatric casualties in the Armed Forces is a matter of common knowledge. It is apparent that they serve the enemy's ends as effectively as do the casualties resulting from physical injury or infection. It is perhaps not so well known that military psychiatric casualties are not limited to personnel with combat experience.

In civilian life psychiatric casualties occur both as the result of direct enemy action (such as has been experienced by our Allies but not, as yet, by us in continental United States), and in the absence of an emergency, but related to war-time conditions. The recognition and treatment of the latter casualties constitute a valuable contribution that civilian psychiatrists can make to the war effort today. This would be a contribution not only towards military victory, but towards minimizing the detrimental effects of war conditions upon the population as a whole. However, this paper is restricted to a consideration of emergency treatment of psychiatric casualties resulting from enemy action against the civilian population.

Civilian psychiatric casualties are of great value to the enemy. One has only to recall recent incidents of blocked roads preventing troop movements and the desertion of vital defense posts, such as those charged with keeping open the lines of communication and transportation, to realize the importance panic can play in the defeat of a nation. To avoid such mass reactions each civilian should be informed of the danger of attack, the anticipated nature of the attack, the defense plans that have been made, and the duties he will be

* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

Note.—The article "Psychiatric Casualties," by Pearl S. Pouppirt, M.D., which appears here was not printed in the "Symposium on Emergency Medical Service" which appeared in CALIFORNIA AND WESTERN MEDICINE for October, 1944, because of lack of space.

asked to perform. All Air Raid Wardens and officers should be given a brief summary of the problem of psychiatric casualties. This should be an informative outline describing in easily understood terms the causes of such casualties, the types expected, their prophylaxis and first aid treatment. Such a pamphlet has been issued in San Francisco by the Office of Civilian Defense.

It should be emphasized that emotional manifestations are normal when an individual is exposed to danger. Such reactions are only considered abnormal when they are out of proportion to the situation and exhibit, for the person, a departure from his habitual (adequately adaptive) reaction pattern. They may render him inadequate to perform his duties, to care for himself and others, or result in him being a nuisance or actual danger to himself and others. If incapacity cannot be accounted for on physical grounds, the patient should be labeled, tentatively, a psychiatric casualty and detained at a first aid station until transportation facilities are available to a hospital where a psychiatric clearance can be obtained before the patient is dismissed. The mistake should not be made of saying that the patient is harmless; therefore, he can be cared for by his relatives. It is precisely this type of patient returning to work suffering from untreated psychopathology, precipitated by danger, who is responsible for fatal accidents with resultant loss of many lives and man hours of work in vital industries. In addition, psychiatric casualties should be isolated because of their infectious nature, and the detrimental effect they have on the morale and efficiency of associates.

Since it is unlikely that a sufficient number of specialists in psychiatry will be available to treat all psychiatric casualties, each physician should be prepared to care for them. The first question he should ask himself is: "Is this patient a psychiatric casualty, and, if so, why did he become one?" The physician must know that if the reaction is out of proportion to the situation, *it is so because of unconscious processes, of which the patient is unaware.* A tactful physician often can obtain a sufficient understanding of these processes to enable him to remove the symptoms in a short period of time. These symptoms should be observed carefully, and thought of as the language by means of which the patient expresses his reaction to *insecurity;* either by flight from it and/or denial of its existence shown by inhibition of activity (apathy, disabling symptoms, amnesia, etc., to coma), or by excessive action due to anxiety or a failure to repress his aroused aggressions (officiousness, belligerency, etc., to mania).

Under emergency conditions attempts at formal classification of reaction types according to some system of psychiatric nomenclature is unnecessary, and often confuses the non-psychiatric examiner, and limits his effectiveness as a therapist.

A complete physical examination is necessary in order to discover any physical injury or illness which may be masked by the psychiatric manifestations. Frequently the presenting symptoms of some conditions, such as cerebral concussion, are psychiatric in nature. Much of the history-taking, psychiatric examination and treatment will be done in conjunction with this physical examination.

A physician cannot approach a psychiatric case with the idea that he can separate his examination, diagnosis, formulation of his plan of therapy and prescription of his treatment. He must be aware that all these factors progress simultaneously from the moment of his first contact with his patient.

The manner of the examiner and the emphasis he places upon questions and parts of the physical examination amount to profound suggestion in the psychotherapy of the patient. Observation of the patient's reactions during the examination, while he recounts his past and family history, and answers questions regarding his family, friends, co-workers, religious affiliations, occupation and damage done to his home or self, will enable the physician to determine what constitutes *security* for this individual.

The physician, by his manner of calm realistic acceptance of the fact that danger exists, that it is being met, and that the patient is in a place of relative safety (because the physician himself and his assistants exhibit no tension), will supply all the assurance that is necessary in a large percentage of cases to obtain a satisfactory history.

If the patient senses the physician's haste (because he has a long list of patients yet to see) the examination might as well be omitted, and certainly should be postponed. One must accept the fact that in psychiatric casualties time must be spent on each patient, and the physician must exhibit an unhurried atmosphere of confidence and courage.

It is of value to be the first person to interview the patient. The exhibition of an interested, sympathetic willingness to listen and try to help gives the patient a sense of security, forming the basis of a confidence which often enables the patient to talk freely.

Patients must be made to feel that the doctor is on their side. It will do no good to assume a hostile attitude demanding coöperation, or attempt to shame patients by comparison with others, or try to appeal to their civic sense and patriotism. A critical attitude will not help. In fact, in many patients it will increase the disability, or perhaps change a somewhat violent, though readily-treated case into a quiet one requiring months or years to cure. These patients are already suffering from guilt because of their fears. To some degree their symptoms are designed (unconsciously) to relieve unbearable feelings of guilt and shame. Reassurance should be given that fear is normal and justified.

Disapproval of the patient should not be expressed by word, manner or deed. Humor, even though well meant, i.e. "to cheer him up," should not be employed. The patient may interpret it as ridicule.

One must bear in mind constantly that the patients are suffering from results of *unconscious mechanisms*. Their symptoms often appear automatically without the patient having the least idea of their mode of development or existence. When one is bewildered, caught in a trap of unconscious conflicts, it is useless to urge him to have self-control, to pull himself together and be reasonable. It will only do harm to tell him that his trouble is imaginary. It is the physician's duty to discover the underlying fears of which the patient is unaware, and to alleviate them as much as possible. Then the symptoms will diminish.

It is enough that the physician understands with what the individual is struggling, imagines himself in his patient's situation and directs his psychotherapy to supply the patient's needs. *Interpretations should not be given to the patient.* He is seeking security, not an explanation of why he is emotionally ill. Nurses, social-service workers, and occupational therapists play an important part in the psychotherapy. Rest, good food, and outlets for energy must be supplied.

Those patients who do not respond sufficiently to warrant prolonged psychotherapy during the first interview should be given as comfortable quarters as possible, and put to sleep with sedatives as required. It is desirable to arrange the next interview with the patient as soon as possible after he has awakened.

If treatment is instituted within twenty-four hours of the onset of symptoms, before crystallization of the reaction pattern has taken place, a minimal amount of disability results; usually a large percentage of such patients can be dismissed in a few days to return to their jobs. However, they should report to some psychiatrist for follow-up and such prophylactic treatment as is necessary to avoid a recurrence when subjected to strain at some future date. The study and therapy of the small percentage who do not respond to the emergency treatment outlined above will be handled best by trained psychiatrists. These patients fall outside of the group dealt with in this paper.

490 Post St.

National Foundation for Infantile Paralysis, Inc.

The encouraging news that "some of the mystery of infantile paralysis is being dispelled" is contained in the annual report of The National Foundation for Infantile Paralysis, made public recently by Basil O'Connor, its president.

Listing grants and appropriations totaling $1,828,859 authorized by the National Foundation between Sept. 30, 1943, and May 31, 1944, for research, education and the training of physical therapists, the present report covers only an eight months period because of a change in the fiscal year. Future annual reports will cover operations from June 1 to May 31.

The report also contains the information that a special fund of $2,000,000 for Epidemic Aid and Other Emergencies has been established by the trustees, as of May 31, 1944, and that last summer's epidemic—the second worst outbreak of poliomyelitis in the history of the United States—drew upon the newly created fund to the extent of $739,860. This expenditure, between June 1 and October 31, 1944, while outside the fiscal period covered by the annual report is mentioned in it as demonstrating the necessity for the establishment of a special fund "for such unforeseen epidemics and other emergencies." The $739,860 of National Foundation funds used to supplement chapter funds in local communities hard hit by the 1944 outbreak.

During the eight months covered by the fiscal report, the National Headquarters received $5,191,148 as its share of the 1944 March of Dimes appeal, an additional $5,293,232 remaining with the National Foundation's county chapters. Receipts from other sources, including $240,000 donated by the producer of the motion picture "Forever and a Day," increased the total income of the National Foundation for the fiscal period to $5,452,593.

That part of the report dealing with research into the nature of the disease is based largely on findings made during 1943, when the number of cases reported, 12,429, exceeded all previous years except 1916 and 1931. . . .

Of the 1943 outbreak, the report has this to say:

"Particularly were extensive investigations conducted in California, Texas, Illinois, and Connecticut. Here workers were able to live in the field with the epidemic. The pattern of spread of cases was investigated. Thousands of specimens were collected in accordance with a carefully pre-arranged plan. Bodily secretions and blood specimens were secured from patients and their contacts. Material was collected from the environment in which these persons lived.

"Wild and domestic animals and birds were studied. Particular attention was given to rodents and animals with any evidence of disease. Large numbers of these were trapped and sent to the laboratories. Food, water, sewage—all were collected.

"The examination of all this material calls for months of study. The laboratory procedures involved are difficult and expensive. They call for the use of high speed and ultra-centrifuges, for monkeys, and above all, skilled and trained laboratory workers.

"Much has been learned from this epidemic. The method of spread of the disease is better understood. Some of the mystery of infantile paralysis is being dispelled. But not enough has yet been learned to set into operation practical control measures. More epidemics need be studied; laboratory methods must be greatly improved before the final answer can be given. . . .

"In seeking improved methods of treatment, it has been necessary to study other diseases," the report states. "The effects of drugs have been studied, not so much by observing their action on infantile paralysis in man, but rather in testing them in laboratory animals infected with similar disease-producing viruses."

"Grants have been made to include studies of other viruses and virus diseases so that the facts learned would both increase the knowledge and develop better methods of study and treatment of infantile paralysis."

Frédéric Chopin (1810-1849).—He was anemic and tuberculous, and it has been said that the taint of disease permeates Chopin's music. But he was indeed "poet of the piano." Once, stopping at an inn for a change of horses, he found a piano in tune and began to improvise. An audience gathered. When he stopped, the caretaker promised him courier horses if only he would play a while longer. Chopin, even when wracked by cough, seemed to lose all exhaustion while playing.—Warner's *Calendar of Medical History.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

LOWELL S. GOIN, M. D.....President
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E. VINCENT ASKEY, M. D.....Speaker
PHILIP K. GILMAN, M. D.....Council Chairman
JOHN W. CLINE, M. D..Chairman, Executive Committee
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-second (322nd) Meeting of the Council of the California Medical Association*

The meeting was called to order in the Patio Room of the Elks Temple at 607 South Park View in Los Angeles on Thursday, January 4, 1945, at 10:00 A.M. The 322nd meeting recessed on January 4th and January 5th, its final recessed meeting being held on January 6th.

1. **Roll Call:**

Present: Councilors John W. Cline, Vice-Chairman, presiding; Lowell S. Goin, E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Sidney J. Shipman, Herbert A. Johnston, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Absent: Councilors Philip K. Gilman (absence due to illness), and Karl L. Schaupp.

Present by Invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; and Howard Hassard, Associate Legal Counsel.

Others Present: Mr. Albee Slade, Legislative Director of the Los Angeles C.I.O. Council; Mr. Mervyn Rathbourne, Secretary-Treasurer of the State Council of the C.I.O.; Mr. E. D. Boyd, Chairman, Employment Committee, A. F. of L.; and Mr. E. W. Bartholomew, Chairman, Accident Prevention, Central Labor Council of Los Angeles (A. F. of L.); and Mr. Von T. Ellsworth of the California Farm Bureau.

2. **Addresses by Representatives of Labor and Agriculture Regarding Legislation to be Submitted by Them to the 56th California Legislature:**

The Council was addressed by Mr. Albee Slade and Mr. Mervyn Rathbourne, representatives of the California Committee of Industrial Organization (C.I.O.), who explained the objectives their organization had in mind in a bill which they stated they would submit to the California Legislature. (Their bill was later submitted as A.B. 449).

Mr. E. D. Boyd and Mr. E. W. Bartholomew of the American Federation of Labor (A.F. of L.), were requested to give their views. They stated the A. F. of L. had prepared no bill, but they were equally interested in safeguarding members of their organization and other citizens from the dangers associated with catastrophic illness.

(California and Western Medicine in its issue of January, 1945, on page 32, under the caption, "Health Insurance on Way, Union Leaders Tell Doctors," printed an item in which additional information is given concerning the general tenor of the remarks made by them and other speakers. On page 40 of the same issue appeared

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

another item concerning this matter. In the February issue of California and Western Medicine additional information was given concerning A.B. 449.)

A general discussion followed in which Councilors asked many questions of the representatives of Labor.

Because the House of Delegates was about to begin its session, it was voted to recess the meeting of the Council until the following day at 9:00 A.M., at which time representatives of Labor would be requested to address the House.

3. **Recessed Meeting of Friday Morning, January 5, 1945:**

On Friday morning, January 5th, the Council met in the Patio Room of the Elks Temple and again listened to further discussion of plans proposed by the representatives of Labor.

At 10 o'clock the Council left the Patio Room to continue its meeting in the Lodge Room, in order to permit all members of the California Medical Association who wished to hear the representatives of Labor and Agriculture (A. F. of L., C.I.O., and California Farm Bureau), these speakers having been invited to then address the Council, with members of the House of Delegates and of the C.M.A. in attendance. This action was necessary because unanimous consent (a parliamentary rule of the House) to have these non-members of the House (in this instance, the representatives of Labor) address the House of Delegates had not been secured, one member of the House objecting thereto. The Council, giving due notice of its intention, used the means of an open Council meeting, in order to permit full presentation by the representatives of Labor and Agriculture, to all who were in attendance at the Special Session.

At the meeting then held, in addition to explanatory talks by Mr. Albee Slade and Mr. Mervyn Rathbourne of the C.I.O., and Mr. E. D. Boyd and Mr. E. W. Bartholomew of the A.F. of L., Mr. Von T. Ellsworth of the California Farm Bureau made an address.

Mr. Ellsworth's remarks referred particularly to measures related to county hospitals and health centers. (California Farm Bureau bills presented to the Legislature are Senate Bills 218 and 219. These receive further comment in items which appear in the February issue of California and Western Medicine, on pages 90-91.)

State Director of Public Health, Wilton L. Halverson, M.D., was called on for remarks.

At the close of the comments by the above representatives, the Council recessed until Saturday morning, January 6, 1945.

4. **Recessed Meeting of Saturday Morning, January 6, 1945:**

The meeting was called to order on Saturday morning at 7:45 in Parlor A at the Elks Temple, John W. Cline, Vice-Chairman, presiding.

5. **Minutes:**

The following minutes of meeting were submitted and actions taken approved:

(a) Council meeting (320th) held in San Francisco, August 6, 1944. (Printed in California and Western Medicine for September, page 151.)

(b) Council meeting (321st) held in San Francisco, December 13, 1944. (Printed in California and Western Medicine for January, page 26.)

(c) Executive Committee meeting (184th) held in San Francisco, August 25, 1944. (Printed in California and Western Medicine for September, page 154.)

(d) Executive Committee meeting (185th) held in San Francisco, October 9, 1944. (Printed in California and Western Medicine for December, page 301.)

(e) Executive Committee meeting (186th) held in San Francisco, November 2, 1944. (Printed in California and Western Medicine for December, page 302.)

(f) Executive Committee meeting (187th) held in San Francisco, December 12, 1944. (Printed in California and Western Medicine for January, page 25.)

6. **Membership:**

(a) A report of the membership, as of December 31st, 1944, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1944: 7,627.

Total members in military service: 2,166.

(b) Upon motion made and seconded, it was voted to reinstate 30 members of the year 1943, whose membership, because of non-payment of dues had automatically lapsed on April 1, 1944; but whose dues had been paid since the Council meeting held on August 6, 1944.

(c) Upon motion made and seconded, Retired Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Harry L. Carpenter, Contra Costa County.
John H. Gray, Monterey County,
J. A. King, Ventura County,
Edward C. Sewall, Santa Clara County.

7. **Financial:**

(a) A cash report as of December 31, 1944, was submitted.

(b) Report was made concerning income and expenditures for December and for twelve months, ended December 31, 1944.

(c) A balance sheet, as of December 31, 1944, was submitted.

Upon motion made and seconded, the above reports were received and placed on file.

8. **Interim Appointments:**

Report was made of tentative appointments made since the Council meeting held on August 6, 1944. Upon motion made and seconded, it was voted that the appointments, which follow, be confirmed:

(a) Dr. R. Stanley Kneeshaw to C.M.A. Liaison Committee of Three, vice Dr. T. Henshaw Kelly, resigned.

(b) Dr. Dwight H. Murray, Dr. George H. Kress, and Mr. John Hunton as a California Committee to cooperate with A.M.A. Council on Medical Service and Public Relations, Dr. J. S. Lawrence, Director.

(c) Dr. C. Kelly Canelo to C.M.A. Committee on Medical Defense, vice Dr. R. Stanley Kneeshaw, resigned, term ending in 1945.

(d) Dr. Louis J. Regan to C.M.A. Committee on Medical Defense, vice Dr. Lewis T. Bullock, resigned, term ending in 1946.

(e) Additional members to "Professional Advisory Committee" of California Bureau of Vocational Rehabilitation: Percival Dolman, San Francisco (Ophthalmology); Charles L. Ianne, Stanford University (Tuberculosis); H. V. Chamberlain, Sacramento (Psychiatry); LeRoy C. Abbott, San Francisco (Orthopedics).

9. **"Liaison Committee of Six" on Medical and Hospitalization Service Plan in California:**

For the Liaison Committee of Six, consisting of three members of the California Medical Association and three members of the Association of California Hospitals, Dr. John W. Cline reported that no further meetings had been held in view of proposed legislation and other matters related to medical care which had come to the front.

10. **C.M.A. Allocation and Richmond Doctor Shortage:**

The following report was submitted by Executive Secretary John Hunton:

Operations of the California Physicians' Service medi-

cal center at Richmond resulted in a loss of $3,620 for the first three months, ending August 31, 1944. A small profit was realized during August, September and October, reducing the six-months' loss to $2,827. In November and December, difficulties were encountered in maintaining competent physicians at the center, with further losses shown for those months bringing the net operating loss at the end of December, 1944, to $3,620. More adequate staff arrangements are now in effect and it is estimated that the center will again reach a self-sustaining basis early in 1945. The original C.M.A. appropriation for this center was $6,000.

11. California Industrial Accident Commission—Fee Schedule and Surcharge:

Legal Counsel Peart reported on the conferences that had been held with members of the State Compensation Fund and with insurance carriers in which Councilor Donald Cass of the C.M.A. Committee on Industrial Practice took part.

Mention was made that representatives of labor organizations were present at the conferences and were much interested in bringing into being the best quality of medical service for injured working men.

Prospective changes concerning the State Industrial Accident Commission and the State Compensation Fund also received comment.

Reference was also made to the fact that, under recent set-ups, a very limited number of physicians seemed to control or supervise at least 50 per cent of industrial accident work.

12. Annual Session:

(a) Concerning the Annual Session which had been scheduled to be held in Los Angeles on Sunday-Monday, May 6-7, 1945, it was agreed that if conditions permitted, President Lowell S. Goin should be authorized to invite one of the guest speakers, the other guest speaker to be invited by the C.M.A. Committee on Scientific Work.

(b) The Committee on Scientific Work submitted a request, suggesting that a secret committee of judges to pass upon the merit of papers presented, be appointed, in accordance with Resolution No. 1 adopted by the C.M.A. House of Delegates in 1944, as printed in California and Western Medicine, for June, 1944, page 307.

The Chairman appointed a committee consisting of Councilors Edwin L. Bruck, Lloyd E. Kindall, and E. Vincent Askey to submit a report to the Council in regard to form of procedure to be followed.

13. "California and Western Medicine":

(a) Editor Kress called attention to the November and December, 1944, and January, 1945, issues of California and Western Medicine, in which the smaller eight point type had been used for the Original Article Department, instead of the larger ten point. Since the number of pages in each issue is limited by the federal authorities, the Executive Committee of the Editorial Board suggested that the eight point type be continued because it would permit the printing of one or two additional scientific papers in each issue.

The Executive Committee of the Editorial Board was authorized to use its judgment in these matters.

(b) Secretary of the House of Delegates Kress asked whether the Council wished the full proceedings of the House of Delegates printed, and if so, as a supplement or as a separate monograph to be sent to each member of the California Medical Association.

After discussion, it was voted that the full proceedings should be printed as a separate monograph and a copy sent to members of the California Medical Association.

14. Malpractice Insurance:

Reports were submitted concerning the malpractice situation, and ordered placed on file.

15. California Physicians' Service:

Attention was called to the action of the C.M.A. Executive Committee (printed in C. & W. M. for June, 1944, page 328), concerning the desirability of the Trustees of California Physicians' Service appointing an over-all manager. After discussion, it was voted that a letter be sent to the Trustees of C.P.S., asking for a report on the preesnt status of negotiations concerning this.

16. State Board of Medical Examiners:

Temporary licensure and other problems concerning licensure of physicians in California were discussed.

Councilor MacDonald spoke of recent conferences with the members of the State Board of Medical Examiners and portrayed some of the difficulties which handicap that Board in its important work. Dr. MacDonald stated the officers of the Board were in full accord with maintaining proper standards of licensure.

17. Auditing Committee Report on Budget:

It was voted to recess until luncheon. At the luncheon meeting, report was made by the Auditing Committee and the Executive Committee concerning the budget and the same was referred to the Council at a later date.

18. Time and Place of Next Meeting:

The time and place of the next meeting of the Council was left to the decision of the Council Chairman.

19. Adjournment:

Upon motion made and seconded, it was voted to adjourn.

John W. Cline, M.D., *Council Vice-Chairman, Presiding*

George H. Kress, M.D., *Secretary*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (45)

Butte-Glenn County (1)

Thompson, Prescott W., *Gridley*

Fresno County (3)

Anderson, Herbert W., *Iowa City, Iowa*
Knudsen, W. N., *Fresno*
Winter, Edna J., *Auberry*

Kern County (1)

Lewis, Leland S., *Bakersfield*

Kings County (2)

Johnson, Karl O., *Hanford*
Levenson, Daniel, *Hanford*

Los Angeles County (24)

Amos, Clarence W., *Long Beach*
Beeve, Edison DeLong, *Long Beach*
Behrend, Ralph Arthur, *Long Beach*
Breuer, Miles J., *Long Beach*
DeLalla, Edmund A., *Los Angeles*
Gramlich, Henry F., *Long Beach*
Hershey, Peter, *Huntington Park*
Holder, Richard M., *Pasadena*
Kimball, Nellie T., *Glendale*
Leix, Frederick, *Los Angeles*
Libowitz, Morris, *Duarte*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Margoles, Clara, *Los Angeles*
Moore-Freshour, Ina, *Norwalk*
Mustard, Flora M. Chambers, *Los Angeles*
Peyton, Thomas R., *Los Angeles*
Potampa, Philip Burnard, *Los Angeles*
Prosterman, Frances, *Santa Monica*
Rost, Paul Carl, *Los Angeles*
Segal, Jacob, *Duarte*
Stephens, John S., *Los Angeles*
Stillman, Freeman Linn, *Los Angeles*
Ver Halen, John J., *Pasadena*
Weiner, Harry, *Los Angeles*
Wright, William Henry, *Santa Monica*

Marin County (1)

Lewis, Ralph Charles, *Point Reyes*

Orange County (1)

Schroeder, Frederick H., *Orange*

San Bernardino County (1)

Graybill, Glen A., *Barstow*

San Diego County (2)

Brandon, Kathryn E., *San Diego*
Smith, A. B., *La Jolla*

San Francisco County (4)

Evans, Robert Sherman, *San Francisco*
Davison, Robert Albert, *San Francisco*
Rose, Carl T., *San Francisco*
Sperry, John A., *San Francisco*

San Joaquin County (3)

Feldkamp, I. M., *Stockton*
Krieger, Isaac Glen, *Stockton*
Wilson, H. K., *Tracy*

San Mateo County (1)

Ring, O. A., *San Francisco*

Santa Cruz County (1)

Murphy, Robert C., *Santa Cruz*

Associate Members (1)

Duvall, Charles W., *Santa Clara County*

Retired Members (13)

Bailly, Thomas E., *San Francisco County*
Beatty, J. David, *Los Angeles County*
Bliss, Guy L., *Los Angeles County*
Carson, George R., *San Francisco County*
Dameron, John Dysart, *San Joaquin County*
Graham, H. B., *San Francisco County*
Haber, William J., *San Francisco County*
Kaelber, Arthur P., *San Francisco County*
Kellogg, E. C., *Los Angeles County*
McBurney, B. A., *Los Angeles County*
Otis, Newton M., *Los Angeles County*
Shields, Lilliam, *Alameda County*
Williamson, Norman E., *San Joaquin County*

Transfers (3)

Arthurs, Elizabeth, from *San Francisco County* to *San Mateo County.*

Powers, Harry J., from *Los Angeles County* to *Monterey County.*

Steelquist, John H., from *San Francisco County* to *San Diego County.*

Resignations (1)

Prentiss, Arthur D., *San Francisco County*

In Memoriam

Baiocchi, Adolph John. Died at San Jose, February 16, 1945, age 53. Graduate of Stanford University School of Medicine, Stanford University, San Francisco, 1919. Licensed in California in 1919. Doctor Baiocchi was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Brown, Dean Cassius. Died at Santa Ana, February 24, 1945, age 63. Graduate of the University of Illinois College of Medicine, Chicago, 1915. Licensed in California in 1924. Doctor Brown was a member of the Orange County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Brown, George Ballantyne. Died at Oakland, March 1, 1945, age 53. Graduate of the College of Physicians and Surgeons of San Francisco, 1918. Licensed in California in 1918. Doctor Brown was a member of the Alameda County Medical Association, the California Medical Assocaition, and a Fellow of the American Medical Association.

✣

West, Jesse H. (Captain, United States Army). Died at Atlanta, Georgia, February 4, 1945, age 47. Graduate of the University of Oregon Medical School, Portland, 1926. Licensed in California in 1926. Doctor West was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Convalescent Troops Follow Progress of War in Films

Convalescent troops are now able to follow the progress of the war by means of "Restricted Staff Film Reports" prepared by Army Pictorial Service of the Signal Corps, Army Service Forces, and distributed to all of the 60 general military hospitals in the continental United States, the War Department announced.

These photographic "reports" are official versions, not available to the public, of combat photography released after review by the Office of The Surgeon General of the Army.

The films are factual and objective, presenting surveys of military operations on all fronts, with explanatory remarks, but with no editorial comment of any kind. Every effort is made to keep them up to the minute. Individual films vary in length from 15 to 30 minutes, depending upon the amount of footage flown back each week from different war theaters and the importance of the pictures themselves.

By an extension of the plan bed-ridden soldiers on U. S. Army Hospital ships returning from the different war theaters to the United States also see combat films.

"Unborn Millions" of War

Europe's "unborn children of World War II" probably equal the total of battle casualties to date. When to their number are added the children dying in infancy from malnutrition and wartime disease, an even larger total is reached.

These infant deaths and the deaths of civilians suffering from malnutrition and disease are the greatest price Europe will pay for the present war.

Discussing the appalling effect of the war on the civilian populations of Europe, it has been pointed out that in many of the occupied countries of Europe peace will find a materially smaller population than existed before the war.

Statistics bearing out this view have been cabled to the *Journal of the American Medical Association.*

In France the birth rate of 1940 and 1941 was 10 per cent below the previous low birth rate. This meant that 120,000 children who might otherwise have been born in those two years were lost to the nation.

Reconditioning News Letter

A new publication *Reconditioning News Letter,* is now being distributed monthly by The Office of The Surgeon General to all ASF hospital commanders and service command surgeons. Its aim is to familiarize hospital personnel with new ideas, practices and procedures connected with the reconditioning program. Sources of the items published are reports made by inspecting officers from The Surgeon General's Office, chiefs of the reconditioning branches in service commands, medical officers and others.

New Hospital Car

On November 13, the first of a new type hospital car for use in the United States was opened for inspection in Washington, D. C.

These new unit-type cars are not converted pullmans, but are designed and built as hospital cars. They are ten feet longer, are air-conditioned, accommodate 38 patients and attendant personnel. Each includes two rows of triple-tiered beds, two compartments with three beds each, a stainless steel kitchen equipped with refrigeration, ice cream cabinet and coal range; a receiving room with four-foot side doors for loading and unloading litter patients; two roomettes, each with toilet and shower, for the medical staff or seriously ill patients; and a baggage compartment. The car also carries a modern pharmacy unit and sterilizing equipment and in case of emergency either the receiving room or one of the roomettes can be converted quickly into an operating room.

The Glenon-type, steel-frame beds are adjustable and unoccupied center bunks can be dropped to provide seating accommodations for ambulatory patients.

Six more of these cars are to be put in operation this month, 18 in December and 75 during January, February and March of next year—bringing the total to 100, in addition to the 120 converted hospital cars now in use.

Tuberculosis, syphilis, cancer, heart disease, and other killers of mankind show no signs whatsoever of adopting a forty-hour week; instead, there is every reason to believe that unless society continues to press its fight against them with undiminished vigor we may shortly see an upsurge in their incidence as we did during and following World War I.—E. E. Kleinschmidt, M.D., *Ohio St. Med. Jour.,* March, 1944.

Eleven Army Hospitals Centers for Specialized Care

Furthering the program for speedy and utmost medical treatment for Army personnel, 11 general hospitals in the Ninth Service Command have been named centers for specialized medical and surgical treatment, Maj. Gen. William E. Shedd, Commanding General of the Ninth Service Command, recently announced at his Fort Douglas, Utah, headquarters.

All patients needing specialized treatment will be transferred to these designated hospitals, where staffs of medical and surgical specialists have been provided for specific types of cases.

At Bushnell General Hospital, Brigham City, Utah, patients with major amputations are given complete reconstructive treatment, including the fitting of artificial limbs and training in their use.

A staff of plastic surgery specialists has been established at Dibble General Hospital, Menlo Park, Calif., where patients with deformities or other conditions resulting from wounds, burns, or other injuries will receive surgical reconstruction. Also at Dibble is the center for eye surgery and the training and rehabilitation of the blind.

Neurosurgery—the treatment of wounds or diseases of the brain, skull, spinal cord, or peripheral nerves—and neurology, which is the medical treatment of functional nerve disorders, are centered in the following general hospitals: Bushnell; DeWitt, at Auburn, Calif.; Hammond at Modesto, Calif.; and McCaw, at Walla Walla, Wash.

All patients with defective hearing are treated at Hoff General Hospital, Santa Barbara.

Patients with disease or injuries of the chest which require thoracic surgery or specialized care will be transferred to Baxter General Hospital at Spokane, Wash.

Surgery of the blood vessels, termed vascular surgery, is performed at DeWitt General Hospital.

Rheumatic fever patients receive care in the favorable climatic conditions of Torney General Hospital, Palm Springs, and Birmingham General Hospital, Van Nuys.

In addition to general medicine, other specialists of Ninth Service Command hospitals are: Deep X-ray therapy—Bushnell and Letterman General Hospital, San Francisco; radium therapy—Letterman; histopathologic—Hoff, Bushnell, and Barnes General Hospital, Vancouver, Wash.; psychiatry—Birmingham, Bushnell, DeWitt, Dibble and McCaw General Hospitals.

Praise for Army Medical Care

Letterman Head in Stanford Talk

Never before in history and in no other army during this war has professional medical care equaled that which the American soldier now receives.

So said Brig. Gen. C. C. Hillman, commanding general at Letterman General Hospital, speaking at the second of a series of popular medical lectures at the Stanford University school of medicine.

"Scientific medicine under the stimulus of war probably has progressed further during the last five years than it would have advanced in several decades of continued peace," declared General Hillman.

Low fatality rates are the result of careful planning, begun immediately after the First World War, he said.

"Medical, surgical, laboratory and x-ray equipment has been designed especially for field use," continued General Hillman. "Means hitherto unknown for the prevention of infectious diseases have been developed. Revolutionary procedures for the treatment of the sick and wounded have been put into use."

Accurate records show deaths from battle wounds in

field hospitals have declined three-fold compared with World War I, while the incidence of infectious diseases is far below the last war and mortality rates of such maladies as pneumonia and meningitis have been reduced materially, he said.

Medical Care for Discharged War Veterans Under Attack

Magazine Writer Charges Inefficiency, Neglect, Racketeering

Charges of inefficiency, neglect, racketeering and callousness in treatment of war veterans in United States Government hospitals were made in March in an article in *Cosmopolitan Magazine* by Albert Q. Maisel. The veterans' hospitals are not the Army and Navy hospitals which care for the wounded of this war prior to discharge from the service. These hospitals handle discharged veterans of all wars, whether wounded or sick.

The magazine, in its March issue, urged, "Let's clean up the veterans' hospitals," and offered what it called a "thoroughly documented exposé of the pitiful conditions under which our war veterans are dying in our Government hospitals."

"Only three out of five veterans complete hospitalization and win even the label of improved," Maisel declared. "The rest die or are discharged as 'unimproved,' or run away to enter other hospitals or to suffer and die quietly at home."

Maisel said that "despite astronomical sums spent for the treatment of these veterans, the Government hospitals are abysmally inefficient compared with State, county and city institutions, and that only one patient in six leaves our veterans' hospitals cured."

Dr. Charles M. Griffith, medical director of the Veterans' Administration, was quoted by Maisel as saying that in 1942, 1,120 veterans died in veterans' hospitals and 1,203 died outside.

"The fact that nearly 60 per cent of all the patients in the veterans' hospitals 'run away' has long been recognized as a sign that things are desperately wrong in these hospitals," declared Maisel.

"The root of the cancer," he said, "is the central office in Washington."

Declaring that statistics in the article were public figures released by the Veterans' Administration itself, Maisel said that "in many of the veterans' hospitals I have visited, the death rates are actually higher, the 'cure' rates far lower and conditions far, far worse than any cold statistics can ever indicate."

Military Deaths in 1944

According to the *Statistical Bulletin* of the Metropolitan Life Insurance Company, the year 1944 was the third in succession in which total military death losses in action, for all belligerents, approached or exceeded the 2,000,000 mark, and the fourth in succession in which the years' toll was on a scale comparable to the annual losses in the first World War. The 1944 figure will probably exceed two millions. This is presented as a considered estimate based on a wide variety of sources, many of which are conflicting.

The United States is the only major belligerent which issues frequent official reports on its battle losses. (Unless otherwise stated, the term *losses* throughout this article refers exclusively to deaths in action or from battle wounds in the military, naval, or air forces.) At the other extreme, the Germans have made no statements for more than two years past regarding their current losses. Estimates of losses even for some of the major belligerents depend, then, on a summation derived from occasional statements on losses in a single campaign or series of campaigns, on the claims and counterclaims of one belligerent with reference to another, and on the published critical analyses of military experts.

American battle deaths in 1944 were the largest for any year in the entire history of this country. The total for 1944 is estimated at about 145,000. This figure, based upon official reports, includes deaths among the wounded, and allowances for probable deaths among the missing and for unavoidable delay in the receipt of death reports.

Our losses last year were about five times those of 1943 and over three times as many as in the 25-month period from Pearl Harbor to the end of 1943. On the Western front alone, our 1944 losses exceeded our total for all of the first World War. It is of interest to note, however, that the maximum monthly rate reached in December, 1944, was not much different from the peak in the first World War, when 19,000 of our men were killed in action in October, 1918. More than four-fifths of American losses last year were sustained by the Army. Moreover, losses among the Marines, chiefly in land fighting in the Pacific area, accounted for about half of the Navy's total. Despite the greatly increased scale of operations by our fighting fleets last year, losses among ship personnel were relatively small.

To Japan, 1944 brought not only the highest losses of any year in this war, but the highest ever suffered by her in any year of war since her contacts with the western world began nearly a century ago. Japan admitted losses of 168,000 killed and wounded in her third year of the war, but careful review of the operations in the Pacific and in East Asia indicates that her death losses were upwards of 350,000, and may well have exceeded 400,000. A significant proportion of this total was incurred in the sinking of troop transports and barges. Her losses of naval personnel were particularly heavy, largely as the result of the two major battles of the Philippine Sea.

The Germans continued to suffer great casualties last year. On the Russian front, where their chief losses were sustained, combat deaths probably equaled or exceeded those of the Russians. The Germans have not only been completely silent on their own losses for some time past but they have been reticent even about losses inflicted on others. Last year witnessed a rapid decline in Germany's striking power everywhere, and a drastic shrinkage of the areas under her domination and control. The Germans have shown themselves masters in the techniques of retreat, but even so, they could not escape heavy losses in view of the long lines they had to defend and in view of the necessity of making a stand at some points in order to protect their main forces during the long retreats. From a careful review of the events, a conservative estimate of Germany's combat losses on all fronts last year would be 800,000 men. . . .

Up to the end of 1944, the present war has cost the lives of about 8,000,000 men killed in action or dead of wounds. This figure is roughly of the same order as the total for the first World War. The major part of the fatalities in the present war have been suffered by Germany and Russia. Each of these countries has lost upwards of 2½ million men, or more than in the first World War. Our own losses now approach or exceed 200,000, that is, between three and four times the total for the last war. Comparatively speaking, the greatest contrast is for Japan, whose losses of more than 600,000 far exceed the aggregate for all preceding

wars in which she had engaged since she first began to emerge as a world power 50 years ago. English and French losses are still well below those of 1914-1918, largely because of the differences in the character of military operations in Western Europe in the two wars.

Shall Army Physicians Also Serve Civilian Army Employees?

Concerning a Recent Questionnaire

Oakland, California, March 5, 1945.

To the Editor.—Enclosed herewith is a copy of a questionnaire form now being circulated within the Army Medical departments and apparently looking toward an extension of Army medical service to all civilian employees of the War Department and their dependents and to the employees of War Department contractors. Where this service would stop is by no means evident.

May I suggest that this questionnaire be published in California and Western Medicine?

Most sincerely yours,
Signed: Signature of C.M.A. Member.

* * *

1. Pursuant to directive form G-4, The Surgeon General is undertaking a study of the provisions of medical care to civilian employees of the War Department.

2. It is requested that you take the following action:

a. Transmit the attached questionnaire to all hospitals and/or dispensaries under your command for completion.

b. Forward all completed questionnaires to this office not later than 15 March 1945 using air mail where practicable.

3. The attached one-time report has been authorized by the Control Division, ASF.

* * *

ONE-TIME REPORT ON PROVISION OF MEDICAL SERVICES FOR CIVILIAN EMPLOYEES OF THE WAR DEPARTMENT AND THEIR DEPENDENTS

1. *Purpose.* Because of the critical shortage of medical personnel and facilities in many communities, increasing demands are being made upon the War Department for the extension of medical services for civilian employees and their dependents *in other than remote or isolated areas.* In order to determine the extent of the increased burden being placed upon the Medical Department, this one-time report is requested.

2. *Definitions.* For purposes of this report civilian employees of the War Department will include:

a. War Department employees.

b. Employees of *War Department contractors.*

3. The Commanding Officer of each reporting hospital or dispensary will:

a. Complete the attached form. The data to be furnished on medical services provided at a hospital or at a dispensary for civilian patients are grouped by the type of civilian served:

(1) Civilian employees of the War Department.
a. Admitted for injury in performance of duty or for disease resulting therefrom (Paragraph 6d, AR 40-590).
b. Admitted for other causes.
(2) Dependents of civilian employees.
(3) Beneficiaries of Veterans' Administration.
(4) Dependents of military personnel.
(5) Civilians under military control (inductees).

The total number of civilian employees at an installation and at all other organizations receiving medical services at that installation is also requested.

b. Discuss the problem of providing medical services for civilian employees of the War Department and their dependents. It is requested that the discussion be guided by the following points:

(1) Are the data entered in the table fairly typical of the installation or were there unusual factors in operation during the period covered by the report which would tend to bias any conclusions drawn therefrom?
(2) What is the current policy in effect at the particular installation relative to the admission and treatment of civilian employees of the War Department and their dependents?
(3) Is the installation located in an area critically short of civilian medical personnel and facilities? If so, to what extent has this shortage affected the work load at the installation?
(4) Is the availability of medical services a serious factor in recruiting civilian personnel and in keeping such personnel on the job?
(5) To what extent is the absentee rate among civilian employees a result of inadequate medical care in the civilian community?
(6) If medical service were provided for *all civilian employees* of the War Department *and for dependents,* what is the probable future load at the particular installation? Hospitallzation load may be denoted by the probable average number of beds that would be occupied by civilian employees and their dependents; the dispensary load may be indicated by the probable number of additional Medical Corps officers required to carry the load.
(7) In light of (3), (4), (5) and (6) above, evaluate the policy currently in effect, as described in (2).
(8) Submit specific recommendations in light of past experience for changes in current War Department policies concerning the provision of medical services for employees of the War Department and their dependents.

Letters from Military Colleagues

V-Mail Letter

From: M. N. Hosmer, Comdr. (MC), USNR,
U.S.S. Langley CUL 27,
F.P.O. San Francisco,
March 7, 1945.

Dear George:

Here we are a hell of a long way from good old S. F. My new duties are interesting but rather rugged at times. I have found that they are really playing for keeps out here and no foolin'. You have probably seen by the papers that the good old Navy is doing quite a job. My part is rather small but it is good to be in on it just the same. I imagine the Japs wish they had never heard of the U.S.A. Give my regards to the boys. . . .

(Signed) Mat Hosmer

* * *

1st Lt. Clark Richardson, 0-548670,
Hq. Co., 3rd Bn., 275th Infantry,
A.P.O. 461, c/o Postmaster,
New York, N. Y.

California and Western Medicine,
San Francisco 8, California.

Hello, *California and Western Medicine:*

I've moved around the world from you—to way over here in Eastern France. Could you change the address? The new one is up in the corner.

We went through a bit of Hell here awhile back. Quite a battle. When casualties come rolling in there's no time to sit back and read the medical journals, but now our sector is quiet and we are able to catch up on news from home.

Along with winning the war over here, the medics also win the friendship of the local people by taking over much of their medical care. Civilian doctors just aren't around so we step in and do much of their work.

So long now. Keep sending California and Western Medicine. It reminds us of home.

(Signed) Clark M. Richardson,
3rd Bn. Surgeon, 275th Infantry.

U. S. Casualties Nearing Million

Total Averaging More Than 2,000 Every Week as Fighting Increases

Washington, March 31.—American casualties will pass the million mark before May 1, if the present tempo of fighting continues on all fronts. And within a year the number will pass the two million mark estimated by retired Admiral Harry E. Yarnell, former Asiatic Fleet commander, as our casualty total before the Germans and Japs are whipped.

For the past several months casualties reported by Army and Navy have averaged more than 2,000 a week. To date there have been 872,862 reported, including 189,541 killed, 515,971 wounded, 70,495 prisoners of war and 96,855 missing in action.

These figures do not include either the bloody totals from Iwo Jima or the stepped-up drive against Germany. It takes more than a month before all the figures from an engagement are included in the totals released periodically by the War and Navy Departments.

Military leaders have been warning that the United States would have to steel itself to shocking casualty figures as Allied forces back closer to the heart of the two Axis nations. Many military authorities say the worst is yet to come.

Total Allied casualties so far, according to the latest available reports, are close to 10½ million, not including civilian losses. According to Prime Minister Churchill, British Empire forces passed the million mark in December, exclusive of 150,000 civilians killed and wounded. Britain, of course, was in the war more than two years before the United States.

Chinese Army casualties for the seven years, July, 1937, to June 30, 1944, numbered 2,802,220, according to an official report.

Russia last reported 5,300,000 casualties during the first three years of the Russo-German conflict. This figure would be larger now.

French losses include 125,000 killed, 200,000 wounded and the staggering total of 915,000 prisoners of war, most of whom are now working in German factories. French authorities reported at the end of 1944 that 80,000 civilians had been killed as a result of bombing and other military operations and that 90,000 civilians had been shot during German occupation.

What enemy casualties have been, naturally, can only be guessed. Russian estimates of Nazi losses on the Red front alone place them at more than nine million. Believed to be more reliable is a report from inside Germany that three million have been killed in action, 500,000 hopelessly maimed and two million wounded. Another one million are prisoners of war.

Japans losses are hardest to estimate. China, fighting since 1937, has inflicted 2,500,000 casualties, according to conservative estimates. Unofficial guess of a high military leader is that the Japs have suffered approximately 1,500,000 casualties from United States action alone.

Total World War I battle casualties were 364,800, including 125,500 deaths. The Muese-Argonne battle of 1918, which lasted 47 days, caused 120,000 casualties.

Fewer Wounded Die Than in First World War

In World War I five out of six men wounded recovered sufficiently to return to active duty, the War Department says. The Army reports that the proportion is much higher in this war. Only one-half as many of the wounded are dying, as compared to the last war. The surgeon general reports that about 3.7 per cent of American wounded have died in World War II, compared to 6.1 for World War I.

Including all action, Russia lost most heavily in the First World War, according to U. S. War Department figures. She counted 9,150,000 casualties. France came next with 6,160,800. Great Britain lost 2,190,235, and Italy lost 2,197,000. Total Allied casualties were 22,104,209 compared with 15,404,477 for the Central Powers. Total casualties on both sides were 37,508,686.

Death from disease in the American forces has been reduced from 12.8 per 100 in World War I to 0.5 per 1,000 in this war.

Casualties are the key to the future draft problems of the country. With the Army pegged for the next three months at about 8,200,000 and the Navy at about four million, the services are now on a replacement basis. In other words, generally speaking, our casualties will have to be replenished by new men to maintain the present size of the armed forces.

Selective Service estimates that about 100,000 men reach draft age each month. Of this number only about 75,000 are found to be fit for combat duty. With casualties more than 85,000 a month, according to the current rate, it is obvious that Selective Service must tighten up on deferments and dig into the reservoir of men in uniform.

Mitigating this obvious numerical shortage, however, is the large proportion of wounded, counted as casualties, who are able to return to active duty.

How many men peace in Europe will release is anybody's guess. General Stilwell estimates Japan has an army of five million men in the mainland of China. If this is true, it could mean just as tough a fight as is now going on in Europe, and even tougher in terms of casualties.

Although so far World War II hasn't taken the toll of World War I, according to figures released, it is known that for security reasons the real story won't be told until years after the fighting. Officials agree that the Allied total of more than 22 million casualties of World War I could be doubled before the world lays down its arms in the present struggle.—San Francisco *News*, March 31.

Mortality Continues at Low Level in 1944

The mortality of the American people was maintained at a low level in 1944, our third full year at war. . . . Fears that the war would seriously affect the health of the civilian population have thus far failed to materialize. The Nation is reaping the harvest of the medical and public health services which it has built up over the years.

But the shadow of war is part of the national picture, and must be taken into account. . . .

The rising tide of war deaths naturally reflects itself in the figures for the average length of life for the group as a whole. . . . In 1944 the average length of life among Metropolitan Industrial policyholders, as computed from current mortality, was 62.8 years, or a loss of 1.4 years from the maximum recorded in 1942. When deaths by enemy action are discounted, this reduction is canceled.

Hutchinson's Triad.—Because of his description of the triad diagnostic of congenital syphilis, Jonathan Hutchinson became especially known as a syphilographer. He was also known as an eminent specialist in at least two other subjects—ophthalmology and dermatology. His name is further associated with the eponyms, "Hutchinson's facies" and "Hutchinson's mask." Ten volumes of the "Archives of Surgery," which he founded and edited, were almost entirely written by himself.—Warner's *Calendar of Medical History.*

COMMITTEE ON SCIENTIFIC WORK

California Medical Association—Re: 74th Annual Session

Meetings Will Be Held in Los Angeles on Sunday, May 6, and Monday, May 7, 1945

Meetings of the thirteen Scientific Sections of the California Medical Association will be held under the auspices of the Los Angeles County Medical Association. This action is necessary because of the rule of the Office of Defense Transportation which aims to do away with unnecessary railroad travel and reduce the load on hotel accommodations.

The California Medical Association has thirteen Scientific Sections. For convenience of reference a number is attached to each of the sections in the list which follows:

SECTIONS

I—General Medicine
II—General Surgery
III—Obstetrics and Gynecology
IV—Eye, Ear, Nose and Throat
V—Anesthesiology
VI—Dermatology and Syphilology
VII—Industrial Medicine and Surgery
VIII—Neuropsychiatry
IX—Pathology and Bacteriology
X—Pediatrics
XI—Radiology
XII—Urology
XIII—Public Health

All meetings will be held in the Elks Temple at West Sixth and Park View, *or* in the headquarters building of the Los Angeles County Medical Association at Wilshire Boulevard and Westlake Avenue. Morning meetings will begin at 10:00 A.M. and afternoon meetings will start at 2:00 P.M., unless otherwise announced.

The use of the Elks Temple and the County Medical Building does away with the necessity of calling upon the Hotel Biltmore to disarrange its own activities to make available the battery of meeting rooms which have been used by the C.M.A. during the last two years.

The facilities in the Elks Temple are excellent from the standpoint of large and accessible meeting rooms. Parking facilities are also good. The House of Delegates will use the Auditorium of the Los Angeles County Medical Association headquarters building, and it is possible that the standing committees may avail themselves of the facilities of the Library Building.

Editorial comment concerning the meeting is also given in this issue.

The usual publicity, with photographs of officers, which in years gone by has appeared in CALIFORNIA AND WESTERN MEDICINE will not be presented this year.

In the *Bulletin of the Los Angeles County Medical Association* having date of April 19th additional information will be given, and likewise in the issue of May 3rd.

However, owing to need of paper conservation, it will not be possible to print abstracts either in CALIFORNIA AND WESTERN MEDICINE or in the *Bulletin of the Los Angeles County Medical Association.*

The complete programs with abstracts of papers to be presented will be given in the *Section Programs* which will be available at the meeting places.

A block outline of the places and hours of meetings of the various sections and other C.M.A. activities appears below.

Building	*Room Therein*	*Sunday Morning May 6*	*Sunday Afternoon May 6*	*Monday Morning May 7*	*Monday Afternoon May 7*
I Elks Temple	(A) Lodge Room (Mezzanine)	1st General Session 10:00 A.M. Lodge Room	Joint Meeting Medicine I Surgery II	Surgery II	Eye, Ear, Nose and Throat IV
	(B) Ball Room (Mezzanine)		Pediatrics X	Medicine I	Obstetrics III
	(C) Rotunda Room (Ground Floor)		Industrial Medicine VII	Radiology XI	Public Health XIII
	(D) Parlor A (4th Floor)			Neuropsychiatry VIII	Pathology IX
II Los Angeles County Medical Association Building	(D) Auditorium		House of Delegates		House of Delegates. Council Organization.
	(E) Dining Room (2nd Floor)		Anaesthesiology V	Dermatology VI	Urology XII

Medical-Military Films.—Restricted Military Films will be shown in Lodge Room of Elks' Temple on Sunday evening, May 6, from 8:00 to 10:00 P.M.

LOCATIONS OF BUILDINGS

1. *Elks Temple.* West Sixth Street and Park View (Phone: FItzroy 5281), Lodge and Ball Rooms on Mezzanine floor (top of stairs). Rotunda on Ground Floor.

2. *Los Angeles County Medical Association.* Wilshire Boulevard and Westlake (Phone: DRexel 7175). Auditorium on Main Floor. Dining Room on second floor. Library at 634 South Westlake.

3. *Council Meeting, 12:30 Noon, on May 5, Town House.* 639 S. Commonwealth Ave. (Phone: EXposition 1234).

CHAPTER IV
RE: COMPULSORY HEALTH INSURANCE BILLS PENDING IN 1945 CALIFORNIA LEGISLATURE (56TH SESSION)

California and Western Medicine for January, 1945, on pages 1-4 and 25-40 presented informative comments and items dealing with proposed Sickness Insurance laws for California.

In the issue of February, on pages 51-53 and 64-92 the items were continued as Chapter II of the series.

In the March number of California and Western Medicine the sequence appeared as Chapter III, pages 123-126.

In the present number of California and Western Medicine the sequence is given as Chapter IV. (See pages 188 to 198.)

Index of Sickness Insurance Items

(The *index* of "Chapter I" of Sickness Insurance items, appeared in California and Western Medicine, for January, on page 40. The *index* of "Chapter II," appeared in the February issue, on page 64. "Chapter III" *index*, on page 123 of March issue. What follows, is the *index* for "Chapter IV.")

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ITEM I

Health Insurance Vote by People Called Sure

Sacramento, March 4.—The people of California will have to vote on whether they are to have compulsory State health insurance, according to experienced opinion around the Capital today on the eve of the reconvening of the second half of the legislative session.

Health insurance legislation was uppermost in the minds of the members of the Legislature arriving tonight.

Conversations with them led to the conviction that none of the health insurance bills now in committee will be passed without important changes. Also, it is argued, the subject will go to a vote of the people even if a health insurance bill is passed, and it will be on the ballot in 1946.

If legislation of the type sponsored by Gov. Warren or the C.I.O. is passed the chances are the doctors and others will join forces and compel a referendum on it. If the bill sponsored by the doctors is passed, its opponents will take it to the people. The C.I.O. announced, in presenting the bill it sponsors, that if it does not pass the measure will be put to a vote of the people as an initiative.

The arguments then swing around the question of what sort of bill can be put through that even the people can vote on.

Whether some legislative genius will be able to bring forth a compromise bill that will satisfy enough on both sides to obtain the necessary votes for passage appears doubtful. They are arguing even as to how many votes will be required—a majority or a two-thirds vote, the latter being required for an appropriation.

Aside from the health insurance measures, Governor Warren has several other items on his legislative program. Indications are that he is not going to have as easy and comfortable a time as he had at the last session. A number of Republicans are critical of some of his proposals, and Democrats will be shooting at him for political reasons.

Warren does not appear worried. He has his genial personality and ready smile and gives no evidence of being perturbed. . . .

With some 3,400 bills to be acted upon and the health insurance measure producing the most lively legislative topic in years, it looks like a very interesting session that will run at least until the middle of May.—Los Angeles *Times*, March 5.

ITEM II

Legislature Reconvenes

Early Clash Over Procedure on Health Insurance Expected

Sacramento, March 5.—As the Legislature reconvened today for the second half of the regular session, indications were that the first clash over compulsory health insurance will come when proponents of pending bills on that subject seek to have them considered by the entire Assembly instead of the public health committee of the lower house.

Authoritative sources close to the committee members declare a majority of the public health committee is opposed to either Governor Warren's bill or the Thomas C.I.O.-sponsored measure.

Compulsory health insurance was the subject most discussed by legislators, lobbyists and others around the Capital as the session got under way.

Tomorrow the public health committee will meet and decide how soon it will schedule hearings on the various health insurance bills, according to Chairman Fred Kraft, San Diego.

Kraft said Governor Warren had informed him he was willing to "accept any reasonable amendments that will make his bill more workable." . . .

Legislative Counsel Fred B. Wood has ruled that both Governor Warren's bill and the Thomas bill, as now written, will require only a majority vote, or 41 in the Assembly, and 21 in the Senate, for passage.

Question has arisen as to whether the bills carry implied appropriations which would put them in the category of requiring approval by a two-thirds vote in each house. But Wood states that the bills in their present form do not carry any implied appropriation.

That whole question will be threshed out later during the debate over the bills, in spite of Wood's opinion. . . .

The Governor has been informed of the attitude of most of the Assembly Health Committee members and is under no delusions as to the type of fight which will have to be waged if that committee holds the hearings on his bill. . . .

Predictions were made in both houses that the consideration of the 3,400 odd bills, constitutional amendments and other matters would require about three months' time. —San Francisco *Chronicle*, March 6.

ITEM III

Compulsory Health Insurance Unlikely to Pass Current Legislature, Says Assemblyman

"Compulsory health insurance has aroused the greatest public interest and has created not only the most enthu-

siastic support, but the most violent opposition," says Assemblyman T. Fenton Knight, just before his return to Sacramento to answer roll call for the beginning of the last part of the current session of the State Legislature.

Following a five weeks' study and survey of public reaction to compulsroy health insurance, Assemblyman Knight states that he has accumulated sufficient information to lead him to believe that the State as a whole is opposed to socialized medicine, or is so divided in support of some one of the four major measures that it is unlikely that any of the bills will be finally passed at this legislative session.

Following is Assemblyman Knight's statement just before leaving for the Legislature:

Bills in Four Groups

"Most of the controversial bills which will consume a substantial portion of the Legislature's time for the balance of the session fall naturally into four groups. These groups are compulsory health insurance, budget control, disposal of State surplus income, and a stabilized tax program.

"Socialized medicine or compulsory health insurance has unquestionably aroused the greatest public interest and has created not only the most enthusiastic support, but the most violent opposition. There are now four major bills dealing with this subject before the Legislature. These four bills cover the entire field of socialized medicine quite thoroughly from left to right. The measure which would most completely revolutionize the practice of medicine in this State, if adopted, is a duplicate of the defeated plan sponsored by Governor Olson in 1939. The bill, authored by men who are in sympathy with the recommendations of the C.I.O. is more liberal in its provisions than the one recommended by Governor Earl Warren in that it would extend medical benefits to our elderly citizens in addition to those eligible to unemployment insurance. The most conservative of these four measures is the bill supported by the medical profession itself, which does not contemplate the levy of any tax not now in existence.

"During the five weeks that I have had to survey and study public reaction on this subject, I have accumulated sufficient information to lead me to believe that the State as a whole is opposed to socialized medicine, or is so divided in support of some one of the four major measures that it is unlikely that any bill will be finally passed at this session. The need of improved medical attention for the citizens of California is generally recognized, but the method by which it should be supplied is not so easily determined. It is on the method and not the need that the present controversy hinges. . . .—Los Angeles *Times,* March 6.

ITEM IV

Health Bill Delayed

Hearings Resume March 27

Examiner Bureau, Sacramento, March 6.—The assembly committee on public health postponed further consideration of health insurance measures until March 27, to give proponents and opponents of the various bills ample time to prepare arguments on what has already developed into the hottest issue of the 1945 regular legislative session.

As the senate does not expect to take up compulsory health insurance until the assembly committee has acted, today's decision by the health committee means that the lawmakers will be marking time on this controversy for the next three weeks.

Assemblyman Fred H. Kraft, chairman of the public health committee, said that another two weeks will be required to transcribe the notes taken during the committee's hearings in San Diego, Los Angeles, San Francisco and Fresno during the February recess. Pending resumption of the hearings here March 27, the committee will clear its decks of scores of noncontroversial bills, Kraft explained. . . .—San Francisco *Examiner,* March 7.

ITEM V

Legislators May Shift Health Bill to People

Sacramento, March 11.—A proposal to take some of the protesting legislators "off the hook" on proposed State health insurance legislation by dumping the highly controversial question into the laps of the people was being noised about the Capital over the week-end.

The proposal, in short, is for the Legislature to enact a State health insurance law and provide therein that it shall be effective only if approved by the people at a general election. The people would vote on it as a proposition on the ballot.

In more than one quarter comment from legislators has been heard that "it is such an important thing that the people themselves should vote on it." . . .

Method Questioned

Whether or not a simple law could be enacted and referred to the people or must take the form of a constitutional amendment was a moot question around here. It was learned today the legislative counsel legal adviser to the Legislature has been asked to look into the matter and give an opinion. Who made the request could not be disclosed.

Legislators who have discussed the matter are reluctant to present proposed health insurance legislation to the people as a constitutional amendment because if it became a part of the Constitution it could be amended only by a vote of the people—a situation highly undesirable in this type of legislation. It might be proposed as a simple enabling act—indicating the desire of the people to have the Legislature enact a health insurance law and declare whether the principle of compulsory tax financing should be employed or whether voluntary participation should be the method.

The usual end to any discussion on health insurance legislation is: "Well, the people are going to have to vote on this anyhow so no use in getting too worked up about it."

Hearings to Resume

Health insurance bills are set for resumed hearings before the Assembly Health Committee March 27. In the Senate the first hearing has yet to be held but it is expected the hearing will be scheduled very soon. . . .—Los Angeles *Times,* March 12.

ITEM VI

The Health Insurance Proposals—I

Governor Warren in advocating his compulsory health insurance proposal voices the hope that further light instead of heat be turned on this controversial subject.

The need for further light to aid a confused public is clearly indicated in the widely varying claims and assertions that have been made at the public hearings conducted by the Assembly Public Health Committee and elsewhere. There are several basic questions to be considered if the people are to be afforded an opportunity for an intelligent decision.

These range from the initial question of whether the people at this time desire the State to act in this field of social legislation to the type of coverage and the ways and means to finance it. Whether or not the present Legislature passes one of the pending measures, the prospect is that the issue will come before the people later at the polls.

Everybody rceognizes the financial, economic and social problems and hardships that unexpected illness can bring

and presumably nobody is opposed to practical measures to alleviate them. It also may be taken for granted that most persons favor every sound measure to protect and to improve the health of our people.

As doctors of medicine themselves have pointed out, medical care is but one phase, however important it may be, of the health problem. Heredity, individual willingness to follow healthful regimes of living, public health measures, and sanitation also are important. Persons who financially are able to command the best of medical care still have their health problems so obviously the answer is not solely a pecuniary one.

Other countries have used various types of health insurance plans but all of these admittedly have their shortcomings. Moreover, what might be suitable for a foreign nation with a different economic background and a generally lower standard of living would not necessarily be desirable in this country. When the over-all health record of this country is compared with those of other countries, there is little question of the leading position maintained by America.

But what is under consideration now is to make readily available without undue financial or economic hardship the benefits of the progress in medical care and particularly to that broad group which lies between the wealthy who need no insurance protection and the indigents for whom the State or local government makes provision.

The medical profession certainly is not opposed to this effort, but from their experience the doctors have their own considered opinions as to how this objective might best be accomplished, and their views merit proper consideration.

While Rhode Island in 1942 adopted a compulsory cash sickness insurance system, the first State system of its kind in this country, its limited scope (which in effect amounted to an extension of the benefits under State unemployment insurance to include sickness) does not afford much experience to guide other States which like California may be considering broader programs. If a State program rather than a national program which would place all States on the same basis is deemed desirable, there are certain questions to be settled.

The first of these, if any State plan is to be adopted, is, whether it should be compulsory or voluntary. Next is the question of coverage. If compulsory, should it apply to everybody or be limited to employees subject to the unemployment insurance tax and their dependents? One bill before the Legislature proposes universal medical care with the cost to be borne entirely by the State.

What are the estimated costs of the compulsory plan about which most of the discussion has centered? Are the provisions for financing it sound, or are alternative proposals more desirable?

These are some of the questions that arise in considering the health insurance proposals which will be discussed further in these columns tomorrow.—Los Angeles *Times,* March 13. (Editorial.)

ITEM VII

Health Insurance Proposals—II

Wherever a system of compulsory health insurance has been used, the number of sick claims invariably has shown steady expansion. That has been true in foreign countries and in Rhode Island, which adopted a compulsory cash sickness plan in 1942 and started disbursements April 1, 1943.

Monthly benefits under the Rhode Island system, which is the first of its kind in this country, pyramided rapidly, rising from an initial $120,000 to $450,000 in a three-month period. A medical examination board was established and the number of claims reduced but later the insurance fund was paying out more than it took in, causing Governor McGrath to recommend to the 1945 Legislature revisions in the law to assure the solvency of the fund.

Arguments as to whether this definite trend toward expansion of claims reflects the value of compulsory insurance in affording medical care to persons previously denied it an account of finances or whether it reflects the incidence of imaginary illness or malingering are beside the pertinent points. These are that this trend points up the difficulty of estimating in advance the cost of any compulsory plan and the obvious importance of being sure that the participants are not misled as to the type and extent of protection and of avoiding later curtailment of benefits. The application of the insurance principle here is not so simple as it might superficially appear, and particularly is this true when the protection offered goes beyond cash indemnities and attempts to make available the medical care itself.

The Rhode Island system ran into difficulties in the cash sickness coverage of employees subject to State unemployment insurance. Under the bill Governor Warren recommends not only employees covered by State unemployment insurance and State and municipal employees but their dependents also would be eligible to the medical care specified. This obviously complicates the efforts to estimate the probable costs.

On the basis of 1943 employment and payroll data, the State Chamber of Commerce has presented some estimates. Figuring the average number of dependents per worker in California at 1.21, it estimates the total number of persons eligible for benefits under this bill at 5,495,000 or approximately 65 per cent of the total population of the State. Another 1,000,000 to 1,500,000 persons, according to proponents of the measure, would voluntarily come under the plan.

Including both compulsory and voluntary coverage, it is estimated that the total income of all persons who would be covered would aggregate $7,486,602,000. Studies of general medical or health service costs in relation to income indicate that the cost of adequate care would require an average expenditure of about 5 per cent of total income. Under the estimate that the Governor's bill would provide approximately 90 per cent of adequate care, the cost would require an average expenditure of 4.5 per cent of income, or $336,897,000 annually on the 1943 basis.

Other estimates based on per person costs ranging from $45 to $62.50 per year run from $298,575.000 to $414,787,000. Since the estimated total revenue to be raised under the bill is figured at $210,656,000, the indicated annual deficit, according to the State chamber study, would be between $88,000,000 and $204,000,000. These estimates as explained are based on 1943 data and if employment and incomes were to decrease after the war the revenues raised under the measure would also be greatly decreased.

Under the tentative provisions of the measure the benefits would become available six months after the payroll taxes started and until the end of June, 1949, the State would provide additional funds necessary to assure operation if revenues from the taxes proved insufficient. The question and the size of a deficit, therefore, are important and the weight of evidence from the experience of other countries and of Rhode Island is that actual costs usually are underestimated. . . .—Los Angeles *Times,* March 14. (Editorial.)

ITEM VIII

Health Insurance Proposals—III

When employees are confronted with the proposal to increase their pay check deductions 1½ per cent for compulsory health insurance, they should bear in mind that there still remains another 2 per cent hike in their old age insurance for their pay checks to absorb.

Under the Governor's health insurance proposal employees would be taxed 1½ per cent up to $4,000 of their annual wages (the maximum for unemployment and old age insurance is $3,000.) Employees are now taxed 1 per cent for unemployment insurance and an equal amount for old age insurance. During the war Congress has frozen the rate for the latter tax at 1 per cent both for employees and employers, but this tax is still subject to a later boost to 3 per cent.

Present payroll taxes which California employers are obligated to pay approximate 8 per cent on the average for workmen's compensation, old age and unemployment insurance. Employers, of course, also face the 2 per cent boost in their payroll taxes for old age insurance to the 3 per cent rate. This together with the proposed 1½ per cent tax on their payrolls for compulsory health insurance would bring the average payroll taxes for employers in this State to about 11½ per cent.

When normal peacetime competition is resumed, increasing the burden of such taxes might well stimulate the installation of labor-saving machinery and the adoption of other means to cut payrolls. Smaller business units particularly would feel the increased tax on their payrolls which certainly would be no incentive for the addition of new employees. Workers who are thus deprived of jobs will not benefit from a State compulsory health insurance system.

The insurance principle admittedly would be stretched if employers and employees were compelled to contribute to a fund from which it is proposed to disburse not for eligible employees alone but for an undetermined number of dependents of such employees. This is a particularly pertinent issue in a State to which thousands of families migrate each year in the hope that the mild, healthful climate will benefit the health of some member of the family.

In considering the urgency of any compulsory measure, it is well to look at what is being done under existing voluntary programs. Many progressive employers in this State have inaugurated sick benefit and hospital plans for their employees. Undoubtedly their example could and should be followed by others.

Sick leave to salaried employees under formal or informal agreements is provided by an estimated 80 per cent of California employers, according to recent information, and the various government units also normally provide for paid sick leave for their employees. The possible effect of the impact of compulsory health insurance taxation on these voluntary aids to employees should be carefully weighed.

One of the strongest arguments for health insurance is that it may avert the catastrophe of doctor and hospital bills which in a case of severe illness can inflict a paralyzing financial burden on a family. But the limitations placed on the services in the compulsory measure recommended by the Governor would cut off benefits just about the point where for most people the doctor and hospital bill problem begins to get really tough. If the proponents of a compulsory measure can figure out the answer to this real problem, they will have something to talk about.

Under individual insurance policies and various group plans it is estimated that more than 1,500,000 Californians are covered in varying degrees by existing voluntary and group programs. A number of alternative proposals to compulsory health insurance are before the Legislature and in these there may well be the means of expanding and popularizing the voluntary programs as well as making broader use of the existing system of county hospitals as proposed in the Farm Bureau bills.

Like the Rhode Island plan which in effect diverted 1 per cent of the employee's 1½ per cent contribution to unemployment insurance to finance the cash sickness insurance, the California Medical Association proposal would provide for payment of cash sickness benefits under the California Unemployment Insurance Act. The doctors' bill would also encourage the joining of State approved hospital and medical care plans by reducing employee contributions to the unemployment insurance fund up to 50 per cent in the case of employees joining such plans.

The voluntary plans avoid the involved administrative setup of a compulsory system which proposes to register doctors and hospitals and to fix fees for specified services. If inducement credits in taxes can be given employees and employers to stimulate the growth of such voluntary plans, they might well supply the answer to the problem of expanding medical care on a practical, sound basis.

California is a large State with a diversified economy and attempts to set up a compulsory system without careful regard to the varying needs of our people and of the medical facilities and doctors that are available to them would invite disillusionment and probably retard rather than advance the progress of medical care in this State.

The whole subject of health insurance and the various proposals pertaining to it now before the Legislature need to be carefully and realistically appraised. Until more proof is forthcoming that the desirable objectives cannot be better accomplished through voluntary systems, the *Times* recommends against the adoption of a compulsory measure.—Los Angeles *Times,* March 15. (Editorial.)

ITEM IX

Warren Opposes Salary Rise in Upper Brackets

Hints Veto Until Policy Devised for Rank and File State Employes

Examiner Bureau, Sacramento, March 14.—Governor Earl Warren declared today that he will not approve any salary increases for superior judges, constitutional officers of the State, or department and bureau heads until a salary policy has been decided upon for the rank and file of State employees. . . .

Public Health

Asked if he would compromise on one of the phases of the health insurance program set up in the Wollenberg-Salsman bills, Warren earnestly replied:

"What I am most interested in is the establishment of a system of public health insurance for the people of California. Everything in the way of detail is less important than that."

Disturbed by reports that opponents of compulsory health insurance are stating that private medical histories would become public records, Warren said he was asking the authors of his bill to offer appropriate amendments.

"Nothing could be farther from the truth than that these records would ever be used to embarrass or harass people," Warren said. "Nevertheless, I am suggesting to the authors of the bill that they add a section making these records strictly confidential, to be used only in the administration of the act.

Records Private

"The records should be private to the same extent that law and medical ethics now make medical histories private. The law already establishes the principle of privacy in adoption cases and workmen's compensation cases." . . .—San Francisco *Examiner,* March 15.

ITEM X

State Survey of Health Bill Costs Urged

Financial Study for Committee Use Asked by Lawmaker

Examiner Bureau, Sacramento, March 16.—An impar-

tial and exhaustive survey of the financial aspects of compulsory health insurance was requested today by Assemblyman T. Fenton Knight, Republican, of La Canada, in preparation for resumption of hearings on the subject March 27 before the assembly committee on public health.

Knight is a member of the ways and means committee and vice chairman of the joint legislative budget committee, which directs the activities of Rolland A. Vandegrift, Legislative Auditor. Knight said he would ask Vandegrift to have the financial study ready in time for use before the committee.

Bring Out Facts

"My purpose is solely to brnig out the facts about the cost of compulsory health insurance," Knight said, "through a disinterested employee of the legislature. Virtually all the estimates and calculations we have received thus far are from partisans.

"We have had estimates from the Governor, the C.I.O. and other sponsors of prepaid medical care bills. We have had statements from the California Medical Association, labor groups and chambers of commerce. But these are all groups which have taken a stand for or against compulsory health insurance, or on particular bills."

Vandegrift on Spot

Vandegrift, former State director of finance, is all but certain to find himself in the middle of a fight if he complies with Knight's request. He has already stated the belief that the prepaid medical care plan sponsored by Governor Earl Warren would cost $100,000,000 a year over and above the funds raised by the proposed 1½ per cent deductions from both employer and employee payrolls.

If Vandegrift sticks to his original statement, he will be accused of sniping at health insurance, and if he changes it, the authenticity of his report will be challenged.

Meanwhile, Assemblyman Fred Kraft, chairman of the public health committee, said the group would hold an executive meeting Monday afternoon to decide on procedures at the public hearing beginning March 27.—San Francisco *Examiner*, March 17.

ITEM XI

Concerning Costs of A.B. 800 (Governor Warren's Bill), and A.B. 449 (C.I.O. Bill)

Opinion of Rolland A. Vandegrift, Legislative Auditor.

The *Assembly Journal* of March 20, 1945, presents an opinion submitted by the California Legislative Budget Committee. Excerpts from Auditor Vandegrift's letter follow:

Mr. Knight asked for, and was granted, unanimous consent that the following Report of the Legislative Budget Committee, compiled by Mr. Rolland A. Vandegrift, the Legislative Auditor, be printed in the Journal:

Legislative Budget Committee
Capitol, Sacramento, California, March 20, 1945
Assemblyman T. Fenton Knight
Vice Chairman of the Legislative Budget Committee

My Dear Assemblyman: Referring to your questions as to the cost of compulsory health insurance as provided for in A.B. 800 and A.B. 449, and secondly, what is the excess of the costs over the taxes proposed in each of the bills, I make the following reply: . . .

First of all, I wish to state that I have not previously made an estimate concerning A.B. 449. I have made an estimate as to the costs of A.B. 800 for the reason that I have been informed that this is the bill which proposes to carry into effect the Governor's recommendation found in his Biennial Message to the Legislature, on page 8; this, I believe, under the provisions of Section 34, Article IV, of the State Constitution requiring a Governor's budget, should have been included in forming the expenditure for the State for the coming biennium. . . .

I have previously estimated that the prepaid medical service, as recommended by the Governor in his biennial address above referred to, in accordance with the Governor's words, "which will bring adequate medical care to the people of our State on a prepaid hasis" (page 9 of the Governor's Biennial Message, lines 5 and 6), and as further set forth in A.B. 800, will cost approximately $100,000,000 a year more than the 3 per cent pay roll tax provided for in this bill. . . .

After carefully examining this bill, A.B. 800, and interpreting the Governor's statement, "adequate medical care to the people of our State on a prepaid hasis," I see no reason to change my estimate.

We may hold differences of opinion as to what is adequate medical care, and, in fact, A.B. 800 departs from this term and declares that the purpose of the act is to provide a System of Prepaid Health Service. This, therefore, does not necessarily mean adequate medical care. It does, however, apparently include both medical and hospital costs. . . .

Based upon the present payroll that would he suhject to this tax and the number of employees thereof and their dependents who would be covered, and adding to this the cost of administration, and using all availahle information, I estimate, on a conservative hasis, that the annual cost to provide services as set up in A.B. 800 which will bring adequate medical care to those covered, and the cost of administration thereof, will exceed the annual income into the fund from a 3 per cent pay roll tax by at least $100,000,000.

I wish to point out to you that this is based on the average annual income of those who would he covered, and the cost for adequate medical services, including hospitalization, at prices which are necessary to huy it on an adequate basis under the terms of the bill, on the basis that 100 per cent of the service rendered will be paid for for all of those covered, and at the expense of the State. It is not calculated that the State will expect a doctor, a dentist or a hospital to provide service and not be adequately compensated.

With any decline in our present economic condition with a material reduction in wages, there would be an immediate reduction in the income of the Health Service Fund. This would undoubtedly be accompanied hy an increased demand for services, but no comparable decline in the cost of providing such services. Under possible conditions, with a larger percentage of our families having a changed status from two or more persons in a family employed to only one, with a consequent increase in the ratio of dependents to worker, the ratio of demand on the fund to income would be further out of balance.

A careful analysis of A.B. 449 presents a little more difficult problem than an analysis of A.B. 800, for the reason that we have no public statement in the way of an official pronouncement other than what is in the bill to interpret it, as we have in the case of the Governor's statement, which we helieve refers to A.B. 800. We are therefore following the established practice of construing the terms of this bill liberally.

The provisions covered under A.B. 449 are, for all practical purposes, approximately the same as in A.B. 800.

The administration expenses, however, are chargeable in their entirety against the General Fund.

The great difference in A.B. 449 is that the payment for all services, with the exception of special medical benefits, hospitalization and laboratory benefits, shall be made on a per capita basis in an amount to be determined by the commission. . . .

The tax to support the costs of the benefits, for all practical purposes, is the same as in A.B. 800. The fact that it applies to another $1,000 of income—while it makes some difference in the actual dollar receipts—will not make such difference in the percentage increase. About the same people will pay the tax and about the same number of people will be heneficiaries as the number in the $4,000 to $5,000 bracket is not large in percentage. About the same medical fees and hospital fees must be paid in order to secure adequate services as in A.B. 800.

There may be less incentive for the doctor to make calls and see patients under A.B. 449. However, to encourage all of the things set forth in A.B. 449, the fees will have to represent a real reward for services rendered.

Considering all of the provisions of this bill, our present economic conditions and the purposes to be secured, it is my opinion that the cost of providing these benefits over the taxes to be collected will show approximately the same deficit as A.B. 800. This is for the reason that, although there may be a smaller demand on this particular fund because the charges for administration and

services rendered by other State departments are not placed on it, the costs are there just the same.

The amount of the deficit in this instance will be influenced somewhat by the number of patients a doctor can and will adequately take care of. If we are willing to accept as adequate medical services the production line system, or a service no better than that they have secured in England under their particular type of socialized medicine, then the annual deficit may be reduced; but if we are to get the kind of medical and hospital service that will satisfy us, the kind that will lead us to believe that each and every one of our dependents and loved ones, in a case of sickness, illness, or accident, will receive the very best care and that we will not live to regret that we did not provide a better service when some loved one passes on, then we will have to pay a sufficient reward to those into whose hands we place the health and even continued existence of ourselves and our dependents. A stipend monthly from the Government can not buy skill, courage, or responsibility when health and life are at stake. It requires adequate reward to compensate, both for success and for taking the risk of failure. Men do not work for monetary reward alone. This has been as true of the medical profession as of any other, and it has brought the development of a high skill and courage. No one, much less the authors of these two bills, in my opinion would wish in any way to reduce the practice of medicine to purely a monetary basis. They must recognize for all practical purposes that the laborer is worthy of his hire, and the fees in both bills must be based on this general principle, else one of the avowed purposes in both bills has not been accomplished.

The foregoing analysis and estimates which I have given you are based on an impartial examination of the two bills you have referred to me. They should not be interpreted by anyone as either advocating or opposing either of these bills or health insurance, or rather, to be more accurate, opposing the procedure of paying in advance, on an insurance basis, the costs of medical and hospital care, which arise in an amount unpredictable for the individual, but which can be actuarially calculated for a large group. . . .

I trust that this will satisfactorily answer your questions, and that you will construe my interpretations of these two bills liberally, and that no one will quibble over these interpretations without being willing to consider the entire matter and the inter-relationship of each and every part with all other parts and with the whole purpose which is provided and expected by the terms of each of these two bills.

Very sincerely yours,
Rolland A. Vandergrift, *Legislative Auditor.*

ITEM XII

Health Bill Changes

Assemblyman Albert C. Wollenberg, San Francisco, one of the authors of the Governor's compulsory health insurance bill, said he would offer changes in the bill to provide, more clearly, that the State Health Insurance System administrators could contract with employers or groups of employees to have workers cared for under existing, voluntary health services, if the services provided are equal to standards set up by the State Health Authority.

The State Chamber of Commerce announced opposition to all the compulsory health insurance bills and sought the creation by the Legislature of a representative commission to study the subject. The committee would render a report not later than one year after its appointment by the Governor.—San Francisco *Chronicle*, March 22.

ITEM XIII

Health Insurance

Warren Says "No" to Medical Body's Advice to Drop Fight for His Plan

..Sacramento, March 24.—Governor Warren gave a flat "no" answer to the California Medical Association suggestion he abandon his fight to secure passage by the Legislature of prepaid medical care for the people of the State under a system of compulsory health insurance.

The Governor's statement was made to reporters today as a result of a move by the doctors opposing compulsory health insurance to have Warren attend a meeting of the trustees of the California Physicians' Service and discuss the C.M.A. program for voluntary health insurance legislation.

In their request to the Governor, the doctors made it clear they wished to discuss the health insurance issue on their own terms, namely that they would not compromise on their position against compulsory health insurance.

Meet April 7

Dr. T. Henshaw Kelly, San Francisco, secretary of the California Physicians' Service, a voluntary health plan group, extended the invitation to the Governor to meet April 7 here with the trustees of the organization.

At the same time it was announced by Clem Whitaker, manager of the doctors' fight against the Governor's health insurance program that Dr. Ray Lyman Wilbur, president of C.P.S., had written Warren a letter regarding the suggested meeting here.

"The doctors are asking me to abandon my efforts to secure for the people of the State a system of prepaid medical care," said the Governor.

Warren said the Wilbur letter in effect was a suggestion "we should turn the health problem of our State over to C.P.S. which is, of course, the brainchild of C.M.A."

Looks at Record

Then Warren looked at the record.

"C.M.A., speaking through its president (Dr. Lowell Goin), denies there is any lack of medical care under our system," said the Governor. He produced a report of a February speech of Dr. Goin at Santa Barbara in which he said: "If there has been a lack of medical care it has been due to superstition, religion, fear or procrastination."

"The idea of turning our medical care problem over to C.P.S. is getting to be perennial," said Warren, calling attention to a move along that line in 1939, a year after C.P.S. was organized.

The Governor said he believed the Legislature had taken to the idea "on representation of C.M.A. that it would solve our problem for us." He said compulsory health insurance had been defeated in 1939, but C.P.S. had "not solved the problem of medical care." The Governor estimated that "not more than 100,000 people are in C.P.S. at this time."

Warren said when his own recommendations for enactment of compulsory health insurance were made "there were three of the major counties of the State in which the doctors refused to coöperate with C.P.S. In some places, it has completely broken down."

Warren told of his own willingness to discuss the problem with the doctors and of a conference with Dr. Philip Gilman, president-elect of C.M.A., last fall. He said he had been "encouraged to believe" by the executive committee of C.M.A., at a meeting sometime back "that there was a common ground on which those favoring health insurance could meet."

Violent Opposition

Warren said the House of Delegates, governing body of C.M.A., however had come out "in violent opposition to any compulsory health insurance program.

"Not one friendly suggestion has been made to solve this most serious of all public questions by C.M.A.," declared Warren. He said he had presented his program "in good faith" but indicated there seemed to be doubt as to the sincerity of the C.M.A. leaders in pushing their voluntary health insurance bill.

"All we meet is bitterness," said the Governor, "and the complaint is made that this is compulsion and therefore the doctors are opposed to it."

The Governor read from an official U. S. Senate on education and labor committee report showing that Dr. Kelly, one of those actively opposing the Warren program now had indicated a different position in testimony at Washington last September.

Warren quoted Kelly's testimony as follows: "We have to be realistic about this (adequate medical care) and in spite of what some of my frineds think and what I am emotionally, you will never get care for all the people unless you make them take it, which means some form of compulsion—whether we are ready for that I do not know."

Answering C.M.A. arguments that compulsory health insurance represented an alien philosophy—born in Germany and destructive of the American concept of Government, Warren cited testimony of Dr. Kelly before the U. S. Senate committee in which the San Franciscan told of the recommendations of a California Senate committee in 1935 that compulsory health insurance be enacted in the State.

Reading from the record, Warren quoted Kelly as stating the 1935 bill had the "approval of the house of delegates of C.M.A., and that the bill was written in collaboration with a special committee of the C.M.A."

Defeated in End

"The proposed act," Kelly testified, according to the record, "underwent startling changes at the hands of the Senate and Assembly and in the end was overwhelmingly defeated, almost all special interests opposing it."

The Governor said his own office was "open" and that he would be glad to talk with the doctors. But he added he believed it was "unfair" for the doctors to put the stamp of alien philosophy on compulsory health insurance "when C.M.A. itself advocated such a bill in the Legislature in 1935 and when the manager of C.P.S. testified in the last six months nothing short of compulsory health insurance could solve the problem."

The Governor said he did not believe that either Dr. Wilbur or the C.M.A. would say that the C.M.A. bill would "solve this problem."

Curiously, the C.M.A. bill now has been amended to take in the chiropractors if any group of persons under a voluntary program wants to engage their services under the terms of the measure.—San Francisco *Chronicle*, March 25.

ITEM XIV

Health Plan Backers Testify

Payroll Tax of 3 Per Cent Sufficient

Sacramento, March 27.—A 3 per cent payroll tax would be adequate to finance California's proposed compulsory health insurance program, according to testimony by witnesses before the Assembly Public Health Committee today.

Nathan Sinai, doctor of public health, University of Michigan, here at the invitation of Governor Warren, opened the bitter tussle in the Legislature over the health insurance measures.

At times more heat than light resulted from the barrage of questions fired at Dr. Sinai by committee members, many of whom indicated hostility to any compulsory health insurance program.

Before Dr. Samuel May of the University of California faculty took the stand to testify in behalf of the Thomas bill, sponsored by the C.I.O., Sinai, a witness for the Warren bill, was subjected to a cross-fire of questions which almost turned the hearing into a forum to discredit the University of Michigan expert rather than to obtain information on compulsory health insurance.

Background Attacked

Ben Read, legislative representative for the California Public Health League, passed around a copy of Who's Who in America to give some of the committee members material for questioning Sinai, a native of Stockton.

Assemblyman Sam Collins, who is principal author on the C.M.A. voluntary health insurance bill, developed the fact for the record that Sinai received his first degree in veterinary medicine, later went into the public health and received various degrees in that field.

Dr. Sinai's record was right smack in Who's Who for everyone to read but much ado was made over the fact that the Governor's principal witness had not practiced medicine.

Then a dispute ensued over who had paid Dr. Sinai's expenses. It developed that the Governor, casting about for someone who had made a study of compulsory health insurance, heard of Dr. Sinai from Dr. Ernest Sloman, San Francisco, president of the State Dentists organization.

Witness' Expenses

William F. Sweigert, one of the Governor's secretaries, told the committee he was authorized to say by Warren that "none of the expenses of Dr. Sinai will be paid out of any funds appropriated to the Governor's office."

In addition, the Governor, according to Sweigert, said "he personally would pay the expenses if necessary."

Rolland Vandegrift, Legislative Auditor, was called upon to cross-examine Dr. Sinai on the latter's figures. Although no policy on compulsory health insurance has as yet been enunciated by the Legislature, Vandegrift bored into the fray with all the fervor of one antagonistic to compulsory health insurance.

Dr. Sinai referred some of the Vandegrift queries to T. H. Mugford of the California Employment Stabilization Committee. Mugford estimated, on a basis of the 1943 unemployment, coverage of 5,672,000 persons would be provided under the Governor's bill. He said the payroll deductions would have amounted to $175,000,000.

Estimate of Cost Given

This, he estimated, would make available for health insurance $30.85 per person to be included under the system proposed. He likewise estimated that the postwar employment would probably make available for insurance needs $27.50 as an average.

Dr. Sinai said he believed that a maximum of $26.50 would be required to meet costs under the proposed Warren program.

The witness gave a detailed statement of all factors involved in the compulsory health program, as he viewed them. He declared the costs of the system could be met from payroll deductions, describing the plan "as feasible, adequate and equitable."

Dr. May arrived at the same conclusions. He characterized Vandegrift's estimates of a $100,000,000 annual deficit under the health insurance programs as absurd and exaggerated.

His Views Have Changed

Before Dr. Sinai left the witness stand he said he had written a book some years ago which expressed ideas widely at variance with his present position. He said he had changed his views after prolonged study of the health insurance question.

Ben Berkov of the California citizens committee supporting the Thomas bill, reviewed the terms of that measure at the night session of the committee.

Dr. Alison R. Kilgore, San Francisco, was the first witness for the opponents of compulsory health insurance. He declared that from 128,000 to 130,000 persons had joined the Voluntary California Physicians' Service. He predicted that enactment of compulsory health insurance at this time would result in a breakdown of medical care in California if the war continued. He asked that action

on the issue be postponed until the 3,000 doctors and 800,000 service men and women had returned home.

Dr. Kilgore quoted from a 1932 book by Dr. Sinai in which the principal witness for the Governor's bill stated compulsory health insurance in other countries had not reduced the amount of sickness. The witness made the point that Dr. Sinai "is not a doctor of medicine."

Other Opponents

Other witnesses listed by the C.M.A. group as against the compulsory health measures included Pat Merrick, State Chamber of Commerce; Wliliam Queale, Fresno; Ronald Ketcham, Los Angeles Chamber of Commerce; Calvin Deming, Agricultural Council; George Shallenberger, Merchants' and Manufacturers' Association; Marvin Greathouse, San Francisco; Dr. Clifford Loos, Los Angeles, and others.

Because of the importance of the hearing, the Assembly adjourned until tomorrow morning after a postponement of the contest over the Governor's State tax cut recommendations. Administration forces, still shy of the necessary votes to prevent approval of the $57,000,000 subsidy of State funds to the local political subdivisions, decided against asking the Assembly to reconsider its action of Friday. At that time, the subsidy supporters earmarked the big grant of State funds for local communities over the protest of the Governor.

Assmeblyman Harrison W. Call, Redwood City, asked that the reconsideration be dropped. Thus the next move will be made when the bill comes back for final action. An amendment to remove all earmarking provisions of the amended Fourt bill and keep it as a clear tax cut measure with no strings attached, either for the State or the cities, is in the offing as a counter proposal to the League of Cities, County Supervisors, Associated General Contractors' scheme to turn the funds over to Mayors, Councilmen and Supervisors.

Biggest event of the day was the commencement of the real action on the compulsory health bills.

Assemblyman Albert C. Wollenberg, San Francisco, who is handling the Governor's bill explained the provisions of the measure to the legislators and a crowd of listeners.

Dr. Sinai's testimony was the highlight of the hearing. --Earl C. Behrens, in San Francisco *Chronicle*, March 28.

ITEM XV

Health Plan Delay of Two Years Sought

Senator Proposes Issue Be Placed Before Voters

Examiner Bureau, Sacramento, March 28.—A proposed constitutional amendment which would block all further action on compulsory health insurance for at least two years, was introduced late today by Senator Ed Fletcher, San Diego, Republican, as the latest move in this hotly controversial legislative issue.

Declaring action should not be taken on health insurance while a million or more Californians and some 3,000 physicians from this State are in the armed service, Fletcher said it was "only fair" to take a "reasonable period" of time for thorough study of the question.

A two-thirds vote by both Senate and Assembly is required to place the proposed amendment on the ballot.

Two Year Postponement

Fletcher declared:

"This constitutional amendment cannot be voted on until two years hence, and this will give us plenty of time to thoroughly study the question and give our absent physicians and citizens in the armed services an opportunity to express themselves."

The proposed constitutional amendment would be submitted at the November general election in 1946. If adopted, it would constitute a declaration of policy binding upon the Legislature. The Governor has no power to veto such an amendment. It goes direct to the people.

The amendment reads:

"It is the policy of the State that a prepaid health service system for the people be created and maintained. The Legislature is authorized and directed to provide therefor by law in any manner not expressly prohibited by the provisions of this constitution."

As the amendment could not be adopted until late 1946, the legislature could not begin drafting a public health insurance system until the regular 1947 session, it was pointed out. Fletcher's plan is expected to gain support in the upper house.

In the Assembly, meanwhile, the public health committee prepared to resume public hearing next Tuesday.

Chief Amendments

Chief administration amendments were introduced by Assemblyman Albert C. Wollenberg, principal author of A. B. 800. They provide:

1. For increasing the proposed employer-employee contribution of 1½ per cent each to a salary maximum of $5,000 annually instead of $4,000.

2. For payment of a cash indemnity, rather than medical and hospital services, to those earning $5,000 or more.

The original bill provided that doctors in the State system could not charge their patients more than the fee fixed for any specific service. The new amendment would give to those earning $5,000 a year or more a cash reimbursement equal to the fee set for the particular service involved.

A patient desiring to pay for the services of a more expensive doctor, for example, would receive $50 in State funds for a particular operation and could use this as part payment of the doctor's higher fees. Wollenberg said only 7 per cent of the State's population is earning more than $5,000, leaving 93 per cent of those in covered employment still subject to the original provisions.—San Francisco *Examiner*, March 29.

ITEM XVI

C.I.O. Makes Two Changes in Health Bill

Sacramento, March 28.—(A.P.)—The C.I.O. announced revision of its health insurance bill today, in the wake of a nine-hour hearing by the Assembly Public Health Committee lasting until midnight last night.

Chief changes in the C.I.O.-Thomas bill premits Christian Scientists and other persons who may object on religious grounds to exempt themselves from coverage and contributions. There is a similar provision in the Governor's bill.

Another change deletes the provision for a State appropriation for administrative costs and puts it in a separate bill, to provide $15,000,000.

Payment for general services is continued on a capitation basis but, through amendment, doctors or groups of doctors would be permitted to choose fee-for-service, the per capita method or a straight salary for certain special services. The Warren bill gives the proposed Health Insurance Commission discretion to use any method.

The changes serve to bring closer together the C.I.O. bill and the administrative measure.—San Francisco *Chronicle*, March 29.

ITEM XVII

How "Panel System" Compulsory Sickness Insurance Was Practiced in Great Britain

(COPY)

26 March 1945.

California Medical Association, *Addressed.*

Replying to your letter concerning panel practice in Great Britain:

My father was a panel doctor in Dublin. My uncle

was a panel doctor in London. I lived with and practiced with both physicians and am thoroughly familiar with the superficial, hit-and-miss nature of panel practice.

While my own relatives did not indulge in such practices, it was well-known that many doctors kept three types of bottle in their offices, a cough bottle, a mixture for stomach trouble, and a mixture for rheumatism.

Patients were not undressed or examined. There was no time for such. Their symptoms were listened to briefly and then one or other of the three bottles was prescribed for them.

The examination and prescribing took perhaps two or three minutes; the filling out of the health insurance forms, reports, summaries, etc., took perhaps five or six minutes per case.

I forwarded a little article I saw in an eastern medical journal last month and he had it published in the Bulletin. It is as good a summary of panel practice as you could want.

Panel medicine is merely a superficial, incomplete type of general practitioner service so far removed from the type of medical care that the average American citizen is accustomed to, that it is to be doubted if it would last for three months over here. The only reason at all that it gets by, is the well-known fact that 70 per cent of ailments are not of an organic nature.

Yours sincerely,

(Signed) (Member of C.M.A.)

ITEM XVIII

How "Krankenkassen" Compulsory Sickness Insurance Was Practiced in Germany

(copy)

March 30, 1945.

California Medical Association,
450 Sutter Street,
San Francisco 8, California.

Replying to Your: Legislative News No. 3

Gentlemen:

I practiced in Berlin under the Krankenkassen system from 1910 to 1936, and am one of those doctors who, from own experience, believe that this system was ruinous to the medical profession and medical art in Germany. To answer your questions:

1. *Restrictions placed on the doctors:*

The *pay* was miserable. The office call was worth the equivalent of 8 to 30 cents, other services in proportion.

To make a decent living from Krankenkassen practice a doctor had to see a great number of patients a day which precluded thoroughness. There were champions who saw several hundred patients a day, owing this business not so much to their medical qualities as to their human skill in making themselves well liked with patients, as well as with the administrations of the Krankenkassen.

During some years it was tried to curb this champion system with a method of making the fees progressively lower with an increased number of patients. This method was abandoned because it was found to be no more dignified than the champion system.

Prescriptions.—They were limited for financial reasons. Expensive preparations, particularly those with patented names were forbidden, and replaced by "Ersatz" preparations, mostly in the form of ready tablets. The art of individually compounded prescriptions was almost forgotten. The amount to be prescribed was rigidly limited.

A book of 250 pages containing the allowed prescriptions in streamlined form, with prices, was on every doctor's desk and constantly used for looking up the allowed prescription in the presence of the patient. This mechanical practice caused many distrustful and sarcastic remarks. I still have this book and shall be glad to let you have it if it is of interest for you. The introduction of preparations into this book often seemed to be due not to their medical values but to the salesmanship of their makers.

If the price of a prescription exceeded the allowed one, the difference was charged to the doctor. Moreover, the total cost of prescriptions during a period of time was limited by the so-called "Regelbetrag," a statistically computed average for any group of doctors. If the sum of otherwise correct prescriptions exceeded this amount, the difference was charged to the doctor.

Expensive diagnostic and therapeutic procedures, as x-rays, laboratory work, physiotherapy, etc., had to be applied for in writing to the administration. The OK's were often limited and inadequate. Many of these procedures were not allowed to be carried out by the prescribing doctor (who was suspected to take financial advantage of them) but had to be referred to Institutes which were run by the Krankenkassen themselves, in a wholesale or assembly line manner. The Krankenkassen did not deny that their Institutes were operated in competition with the doctors.

Paper Work of Physicians.—A terrible bother was the writing out of numerous slips, records, prescriptions, reports, etc., which was very much in excess of what is done in private practice. Much of the short time available for each patient was taken up by paper work before the doctor could even take a look at the patient.

Few doctors could afford a secretary for this work.

2. *Supervision:*

The most serious source of irritation and depression was the overbearing attitude of the administrative organs, the *non-medical* bosses, who treated the doctors with purposeful humiliation. For example, extra fees for night calls applied only for the hours 10 p.m. to 6 a.m., which meant that a *16 hour working day was taken for granted* and a doctor's time of rest was not sufficiently respected.

When deductions from the pay (s. above) were made, which occurred with almost every check, no reason for the deduction was given. The doctor was not esteemed to be given an account. He could ask for information and even apply for rectification, but this procedure was made so unpleasant and time-consuming that rarely a doctor made use of it. He let it go and took the unnamed deduction for granted.

Some doctors learned to be good politicians in order to get along with the administration.

If a doctor had to deny a patient a prescription or a treatment because it was too expensive, he was not allowed to tell the patient this reason or to say that it was not permitted. He was compelled to explain to the patient that the treatment in question was not indicated (so-called "muzzle paragraph"). Any direct or implied criticism on the Krankenkassen was prohibited under severe penalties.

Any attitude of the doctor which could be construed as a violation of respect of the administration could lead to exclusion from Krankenkassen practice.

The doctor had not the right to refuse a patient. In exceptional cases he could complain to the administration about a patient. This happened rarely; the doctors served drudgingly. On the other hand, complaints of patients against doctors were not infrequent and were feared by many doctors.

The name *"compulsory health insurance"* was mostly justified by the fact that the *bulk of the compulsion was directed against the doctors.*

3. *Overhead expenses:*

They were very high compared with the funds for the doctors. I do not recall figures, but I believe to remember that the expenses for administration were about equal to the funds used for doctors' fees, if not higher.

4. *Background of the German "Krankenkassen System":*

For the understanding of the German system it is important to remember the political and psychological backgrounds of it.

At the time around 1880 Bismarck and his class were very much afraid of the rising tide of socialism. Along with treating the working people harshly they wanted to give them a pacifier and invented for this purpose the social insurance. The Prussian aristocratic rulers had no qualms to sacrifice the medical profession for their political purpose. Out of a deep-seated superstitious prejudice (another manifestation of which was their anti-semitism) they feared and hated physicians and looked down on them condescendingly.

On the other hand, in the education and social position of the medical men *charity* was much more stressed than healthy self-assertion, so that it could easily be made a pretext for exploitation.

The Krankenkassen were given self-rule ("Selbstverwaltung") and were administered by men who were more or less leaders in the socialist movement. They saw in the doctors' members of the capitalist or bourgeois class and, being the employers of the doctors, made them a target of their political resentment.

German medicine was caught between two political millstones. With the gradual extension of the system over increasing parts of the population and corresponding elimination of private practice the medical profession became progressively enslaved and impoverished.

I was for many years an officer of several medical societies and a member of the Arztekammer (Chamber of Physicians) in Berlin and had personal knowledge of quite a number of cases of doctors who died penniless and left their families to the charity of the professional organizations.

Very sincerely yours,
(Signed) (MEMBER OF C.M.A.)

ITEM XIX

Health Plan Checked

Two-Year Delay Urged on State Health Plans

Examiner Bureau, Sacramento, April 3.—Seven assemblymen, comprising a majority of the committee on public health, have signed a report recommending in effect against the enactment of any health insurance legislation at this session, it was announced today by Assemblyman Fred H. Kraft, committee chairman.

The same seven who signed the report late tonight voted "no" on motions to report out the two major bills with a "do pass" recommendation. While this was not equivalent to tabling the bills, it has the same practical effect, leaving them still the property of the committee.

Two-Year Study

Kraft said the majority of the thirteen man committee favors appointment of an assembly interim committee, adequately financed, which will make a two-year investigation of all phases of health insurance, both compulsory and voluntary, and report back to the Legislature in 1947.

If the assembly accepts the committee recommendation as it now stands, Governor Earl Warren's compulsory prepaid medical care program and a dozen other health plans, have no chance for passage this year.

The action of the committee is by no means final, however, and Kraft's announcement came as a surprise to Assemblyman Albert C. Wollenberg, principal author of the administration sponsored health insurance plan.

"It was no secret to us that the public health committee has a majority unfriendly to compulsory health insurance," Wollenberg said.

Vote Asked Now

"The Legislature of California has been investigating health insurance for thirty years. We do not need any more investigation. What we need is a Legislature that will meet its responsibility by voting on the health insurance bills now before it.

"I shall fight for a vote on the floor of this house."

When the committee report is filed, Wollenberg explained, the assembly has the option of accepting or rejecting it. Also under consideration is a move to take the health insurance measures completely out of the hands of the committee. This could be done by a mere majority vote of the assembly, and is a recourse frequently adopted when the members feel that a measure is not getting fair treatment.

Coalition Seen

The Democrats, it was pointed out, have strongly endorsed the principle of compulsory health insurance. If the fight is taken to the floor on a question of pulling the bill out of committee, many observers believe that a coalition of Republican and Democratic supporters of health insurance might succeed in overriding the recommendation of the Kraft group for a two-year delay.

Voting with Kraft, San Diego Republican, to defer action for two years, were:

Republicans: John F. Thompson, San Jose; Richard McCollister, Mill Valley; C. Don Field, Glendale; Sam L. Collins, Fullerton.

Democrats: John W. Evans, Los Angeles; Fred Emlay, Salinas.

Kraft's announcement was made as his committee began a final hearing today at which sponsors and opponents of the controversial measure were heard. In view of the fact that the committee's attitude was already known, today's hearing was something of an anticlimax.

The majority report of the committee stated there is "deep seated disagreement" on every phase of health insurance. It declared:

"To embark on any scheme of compulsory health insurance would be a revolutionary change in the field of medical care, with far reaching consequences, both as to the future quality and standards of medical service and the way of life of our people, which cannot be planned or directed in advance."

Deficits Likely

Holding that it is impossible to anticipate the costs of such an insurance program, the report found that the plan "may result in large annual deficits that would require resort to the general fund or result in insolvency or failure of the program."

Doctors Ready to "Call Bluff"

The California Medical Association through its executive secretary, John Hunton, declared tonight that it is ready to "call the bluff" of those who are trying to convince the public and the Legislature that some form of compulsory Government health insurance is inevitable.

"There is no concerted movement in Washington today to get action on a Federal plan of compulsory medicine," Hunton said before the assembly public health committee. "Both sides to the argument have decided that winning the war comes first.

"Then you have been told that if the Legislature fails to enact a compulsory health insurance program, that the C.I.O. will initiate an act and place it before the people at the next general election.

"I think it is about time we called that bluff.

"If the C.I.O. wants to submit this measure to the people, then by all means let them get at it. The doctors of California are ready to accept that challenge, and we have complete confidence that the voters of California will reject State medicine by an overwhelming majority."

The C.M.A. also presented results of a Statewide poll taken by John B. Knight, of California Associates, a public survey organization with headquarters in Los Angeles, showing that only 26.1 per cent of California citizens would go to State panel doctors, and that 73.7 per cent of the citizens would not use the State system but would continue to depend upon private physicians for medical attention.—San Francisco *Examiner,* April 4.

ITEM XX

An A. F. of L. Publication Gives Labor's Viewpoint on Compulsory Sickness Legislation.

(Courtesy of National Physicians Committee)

(COPY)

THE LABOR UNION

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* * *

Editorial

THE LABOR VIEWPOINT

Dangerous legislation.

Some of it is dangerous to one class of individuals and some of it is dangerous to another group, but now here comes proposed legislation which is dangerous to all alike.

This is legislation which editorial writers the country over are opposing, and while there are a few good features in the new Wagner Bill—aimed at socializing medicine—few if any of the leading writers can find sufficient good in the Bill to commend it to the public.

"It is doubtful if any legislation has been proposed for Congress that is quite as vicious and deceptive, or that could be more destructive of both human freedom and human self-respect than the new social security bill offered by Senator Robert F. Wagner, of New York City," says an editorial in the Shreveport (La.) Times.

The Times editorial points out that the purpose of this Senate Bill 1161 is its use as a means of enacting into federal law the proposal of President Roosevelt for expansion of that phase of bureaucratic activity of the government.

* * *

The bill would add $12,000,000,000 a year to the taxes of the public, with one-half of it placed directly on the payroll workers.

Under the present system of handling social security that tax money would be available for any government spending, which would mean that in the future years new taxes would have to be imposed to pay the obligations of the social security taxes spent for other purposes.

What this plan proposes for the United States is exactly what Mussolini tried for Italy and what Hitler has been trying to put over in Germany.

What the Congressmen backing this plan are asking the free people of the United States to do is to follow the course that helped put Italy into Mussolini's slavery and then destroyed the people of the nation.

It is a potential final spearhead by which bureaucracy could destroy democracy, freedom and self-respect among American people as a whole.

* * *

What this medical proposal really means is the abandoning of the private practice of medicine and in the end placing medical aid, care and attention under politically selected and approved doctors, druggists, nurses and hospitals.

The right of the citizen to pick his own doctor would be wiped out in the end.

Of course the bill does not in so many words abolish private medical practice as such.

But it makes private medical practice impossible economically, and undesirable from any standpoint.

Under this plan, the American citizen would find that whenever sickness came he would be herded before federal doctors, in federal clinics or federal hospitals, and given mass federal treatment.

Instead of improved public health, such a plan could only in the end destroy it.

Instead of profiting through "government-paid" medical attention, the citizen would find himself a political pauper from the standpoint of health, paying in taxes perhaps $100 for every $25 worth of so-called "service" received.

* * *

What the American public, and particularly the laboring class, should clearly understand is that this plan is not simply a blow aimed at the medical profession, but part of a huge armored force attack which is battering the whole front of freedom, initiative, enterprise, liberty and self-respect for all of the American people.

Fascism, dictatorship, Naziism, Communism or any other "ism" could not come into the United States by one fell swoop—by any overnight governmental action.

Designers of such radical governmental changes move slowly with caution; they build their house stone by stone so that no one step attracts too much attention.

Suddenly it is found that an entire new structure is completed.

It is too late then for Liberty and Freedom to act.

Every step taken, every stone laid, was done in the guise of "helping" some citizen group, of putting money into its pocket, or of making unnecessary the removal of money.

* * *

Actually such programs form one gigantic steal of the citizen's money as well as of his decency, liberty and self-respect.

The bureaucrats insist their political medicine is to build up public health when all it could do would be to build up the politicians and their power.

It is simply one of many similar steps to destroy initiative in one group as similar steps are taken with other groups.

If the medical profession can be destroyed, so can the legal profession, engineering, school teaching, or any other.

There is no problem so needing solution as that of top-grade medical attention for those who cannot pay top prices.

But taxing the workers thousands of dollars to be spent by some medical dictator set up by bureaucrats is no solution.

* * *

At a time when medical science is performing seeming miracles in the discovery and application of new healing agents and operating techniques, and while thousands of American doctors are away in the armed forces serving America and all mankind, along comes this proposal to socialize medicine, as part of a broad scheme to provide "security" for the general public.

The Constitution of the United States gives every man the right to "his day in court," before he can be "counted out" of circulation with his fellow men, although he may be known to be a criminal. But is the medical profession of America being given its "day in court"?

Those members of the medical profession who are risking their own lives on the far-flung battle fronts of the world in behalf of your fathers, sons or sweethearts

—yes, and of thousands and thousands of the womanhood of America, since women are now in every branch of the service—do not have the time nor opportunity to protect themselves from this "stab-in-the-back," which the Wagner bill undoubtedly is.

* * *

The small force of physicians and doctors left in the United States to look after all the millions of war workers and to try to keep the nation in as healthy a condition as possible, are little if any better off than those outside our shores with regards to time to look after their own welfare and the protection of their profession.

Thus it behooves every worker to do all possible to protect his own interests and those of his doctor by fighting this dangerous Wagner Bill, which is Senate Bill 1161. Let your Senator and Representative in Congress know that you want this bill defeated.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

A. F. of L. Decries Concentration of Power in Washington

The views of the American Federation of Labor on this subject are most forcefully expressed in a statement issued by a group of its leaders on February 4, 1940, from which I quote:

"One of the great drags upon industry during the past seven years has been the burden of taxation that has been imposed upon big and little business. There are literally thousands of industrial and commercial concerns which have been forced into red figures by the taxes which have been imposed on flagging business.

"With money taxed or borrowed from the people the Federal Government has set up a multitude of public and semi-public corporations, which have gone into the States to weaken the authority and the financial soundness of the States.

"In many of these instances the Federal corporations and agencies have gone far beyond the intention of the authority which was granted to them by the Congress. But steadily and surely they have undermined the sharp line between State and Federal authority to increase the concentration of power in Washington.

"As labor and industry survey what has happened to labor and industry in those lands where all powers have been concentrated in the central authority, they fear and oppose the steps which thus far have been taken here, to enlarge the dominion of the Federal Government over the lives and fortunes of the American people.

"It is not a problem for labor alone, or industry and agriculture alone. It is a problem which must be solved by an awakened citizenship. It is a problem to be discussed at every fireside, to be dealt with by every publicist, to be prayerfully considered by those Americans who this year will be called upon to draft the platforms of both political parties.

"The hour has come for Americans to recognize the dangers that confront them, and to join in a united effort to halt the drift toward national insolvency and industrial collapse, and to extend opportunity for the Americans of today and tomorrow."—Robert B. Dresser in *The Railroad Workers Journal.*

The first to write specially on the study of the urine, its color, consistence, and the prognosis to be drawn from it, was Theophilos (610-641), surnamed *"Protospatharios,"* a title originally given to the colonels of the bodyguard of the Emperor at Constantinople.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Proposed Plans for the Three Blue Cross Hospitalization Groups of California

(COPY)

Association of California Hospitals

1182 Market Street, San Francisco 2, Calif.

San Francisco, March 3, 1945.

Mr. H. E. Heerman, Chairman,
Board of Directors,
Hospital Service of Southern California.

H. Gordon MacLean, M.D., Chairman,
Board of Directors,
Hospital Service of California.

Mr. J. D. Stephens, Chairman,
Board of Directors,
Intercoast Hospitalization Insurance Association,
Addressed.

Gentlemen:

Attached hereto is a copy of report of the Committee of Three to the Board of Trustees, Association of California Hospitals.

This report was unanimously approved and the committee was given full power to act under the provisions of this report.

Since the initiation of Mr. Williamson's work depends entirely upon the agreement of the officials of the existing Blue Cross plans, we request that you call emergency meetings of your governing bodies and approve a formula for a statewide Blue Cross plan.

Cordially yours,

J. V. BUCK, *Chairman,*
Committee of Three,
Association of California Hospitals.

* * *

(COPY)

San Francisco, March 3, 1945.

To: The Board of Trustees,
Association of California Hospitals.

From: The Committee of Three.

Your Committee has taken the following action and makes the following recommendations:

(a) The Committee has employed Mr. Kenneth Williamson, secretary to the Council on Association Development, American Hospital Association, Chicago, to act as field representative in securing legal agreements of hospitals participating in Blue Cross plans, whereby said hospitals accept financial responsibility in Blue Cross management and control of Blue Cross plans. He will work during the month of April. Salary, $750.00 per month with all living and transportation expenses paid by the Association of California Hospitals.

(b) The Committee proposes to the Blue Cross plans the following procedures:

1. Legal representatives and Blue Cross boards of control immediately agree on legal basis of merger. The two immediate objectives are:

 (a) That hospitals serving Blue Cross patients legally agree to become financially responsible for Blue Cross plans. This does not mean that additional subscriptions to operating surpluses or re-

serves are necessary. It does mean that the participating hospitals will become financially responsible for future operations of Blue Cross plans.

(b) That the participating hospitals shall elect a board of control in conformity with the recommendations of standards set up by the Blue Cross Plan Commission; the essential factor being election by participating hospitals of board of control for Blue Cross plans, one-third of the members of which represent the participating hospitals, one-third the medical profession, and one-third the public. As a basis of allocation of representation on board of control of the Statewide Blue Cross plan, it is recommended that such representation be equally divided between the two sections of the State north of the Tehachapi Mountains and that to the south.

It is recommended that all details of operation of the Statewide Blue Cross plan, such as method of payment for Blue Cross hospitalization, etc., be subject to the decisions of the board of control, as constituted under recommendations made in section (b).

Your Committee of Three recommends to the Board of Trustees the approval of the above actions and recommendations of the committee.

COMMITTEE OF THREE OF ASSOCIATION OF CALIFORNIA HOSPITALS,
(by) J. V. BUCK, *Chairman*,
A. E. MAFFLY,
WILLIAM P. BUTLER,
A. A. AITA, *ex officio*.

* * *

Action on the above: The trustees of the Association of California Hospitals approved the recommendations submitted by the Committee of Three.

Curriculum for Medical Technicians, University of California.—The need and demand for well trained personnel for service as medical technicians has led the University of California to establish a four-year (eight-semester) curriculum in this field, leading to a Bachelor of Science degree through the School of Public Health in coöperation with the University Medical School. Instruction will be offered on the Berkeley campus with the exception of the final semester which will be given on the San Francisco campus.

Inquiries regarding details of this curriculum may be addressed to Dr. Walter H. Brown, Acting Dean, School of Public Health, 3583 Life Sciences Building, University of California, Berkeley 4, California.

Kaiser Permanente Foundation Hospital Has New Family Health Plan

The San Francisco *News* for March 19 carried an interesting story concerning the Permanente Foundation Hospital in Oakland. Excerpts follow:

Details of a new family health plan, in effect at the Kaiser shipyards, providing for medical and hospital care for worker, wife and minor children, have been announced by Dr. Sidney Garfield, director of the Permanente Hospital Foundation.

The family plan supplements the employee health plan —which covers individual employees only—but does not displace it.

Before the family plan was effected, an employee paid 50 cents weekly for his personal coverage. Now, for an additional 75 cents weekly, his wife is provided for, and the cost to the employee for child coverage is 50 cents for one child and $1 for two or more children. Thus the maximum cost, irrespective of the number of minor chlidren, is $2.25 a week per family.

The family plan is open only to shipyard employees who hold the gold anchor pin—those with 18 months of employment with a clear record—and executives and others who are exempt from punching timeclocks.

"Our only regret is that we cannot make it available to all our employees at this time," said C. D. Bedford, vice president and general manager in Richmond. "We hope to arrange medical and hospital facilities to accommodate the families of every shipyard employee in the near future."

For the time being, employees and their families are being enrolled without physical examination. After 30 days, examinations will be required. If one member of a family is rejected after examination, all other members remain eligible.

Individual employees not eligible for the family benefits will continue to be covered for 50 cents weekly, and an employee in this category may obtain obstetrical services for his wife for a $200 fee—including pre- and post-natal care, medicines, use of delivery room, doctors, nurses, hospitalization, maternity ward, and care of the infant during confinement.

Subscribers to the family plan receive this service for an additional charge of $60.

During the period of the "national emergency," a charge of $2 will be made to families for home calls by doctors, but home calls by Permanente visiting nurses will be free.

Ambulance service is provided within a radius of 30 miles from the Richmond or Oakland hospitals.

Diseases and illnesses excluded under the plan include those for which the member is entitled to compensation under State or Federal compensation laws, mental illness, attempts at suicide, tuberculosis, diseases requiring isolation and diseases that become epidemic, and diseases or hurts resulting from "the public enemy or major disasters."

Dental work—save for diagnostic use of the X-ray is excluded.

The plan is wholly voluntary, and payment made by payroll deduction.—San Francisco *News*, March 19.

Immune Serum Globulin: Its Use for Measles

An announcement has just been issued by the American Red Cross that immune serum globulin (gamma globulin) for the prophylaxis, modification and treatment of measles is now available for the civilian population without charge. The American Red Cross has funds appropriated, enabling the organization to meet the entire cost of processing and delivering this globulin to State Health Departments, so that the excess over the needs of the armed forces may be given back to the American people who have made it available through the American Red Cross Blood Donor Service.

As long as their present stock lasts, we shall be supplied on the following conditions:

1. That the product will be used for the prophylaxis, modification and treatment of measles.

2. That it will be distributed without charge to physicians, hospitals, and clinics in accordance with applicable laws and regulations.

3. That it will be administered in accordance with established standards and without any charge to the patient for the product.

The State Department of Public Health has a supply of this product on hand. In making request for literature or placing your order, please address it to:

State Department of Public Health,
Bureau of Acute Communicable Diseases,
1122 Phelan Bldg., 760 Market Street,
San Francisco 2, Calfiornia.

CALIFORNIA MEDICAL ASSOCIATION

REPORTS OF GENERAL OFFICERS, C.M.A. COMMITTEES AND COMPONENT COUNTY MEDICAL SOCIETIES

FOR CALENDAR YEAR, 1944

(For Index of Reports, See Page 234)

FOREWORD.—The official reports which follow will be presented at the coming session of the House of Delegates.

Delegates, therefore, are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations in these reports, and to discuss them with other members and delegates.

Through such coöperation, action that will be in line with majority opinion, is more apt to be taken.

* * *

I

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the House of Delegates:

Neither this body nor the Association needs to be told that the California Medical Association and the entire profession of Medicine in California is in a position of great peril. Indeed the entire profession of the United States may be said to be imperiled since it is obvious that interests demanding compulsory health insurance are using California as a sort of proving ground.

It is indeed comforting to know that almost every member of the Association is determined that the private practice of Medicine and free enterprise shall be preserved and that the California Medical Association shall not stand by complacently while revolutionists weld the golden chains of security about the necks of our people.

It is my earnest plea that regardless of all personal opinion; that even though some individual member would have conducted himself or the affairs of Medicine differently; that even though individual members feel and voice criticism of those who must needs spearhead the battle, all members will submerge these differences and standing shoulder to shoulder lead a fight which will be so victorious that the planners will hesitate to try again to enslave a great profession.

Respectfully submitted,

LOWELL S. GOIN, *President.*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

Travel restrictions and duties with the Navy have made it impossible to carry out, except in the San Francisco bay area, the customary visits to the county societies.

Your President-elect has attended the meetings of the Council and the Executive Committee.

Respectfully submitted,

P. K. GILMAN, *President-Elect.*

REPORT OF THE PAST PRESIDENT

To the President and the House of Delegates:

The experience of the Past President during the last year convinces him more than ever that the Past President should not hold a seat on the Council of the California Medical Association.

It seems to me that the Council is already too large and the men who should be active and should hold positions are the younger men who are going up in the Association and who will have to carry out the policies which they formulate.

I am sure any of the men who have served as President will be glad to consult with the Council or Executive Committee when occasion demands, but to serve regularly on such a body becomes an anticlimax. I, therefore, heartily endorse Dr. Goin's resolution.

Respectfully submitted,

KARL L. SCHAUPP, *Past President.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

Little need is apparent to recite the happenings of the past year. Indeed, our motto with the experience of the past must be, "Look forward—not backward."

Your Speaker was honored in being your Chairman at one of the few historical, special meetings of the House of Delegates. At that meeting, re-affirmation by the California Medical Association was made of opposition to Compulsory Health Insurance schemes. These bills were, in my opinion, un-American in principle, faulty in form, obnoxious in purpose, and deceptive in origin. Though government has the right to make radical changes, yet we are privileged also to object to such changes by legal processes. That has been the attitude of our Association.

This year, following the meeting of the Legislature, with the Armed Forces still in battle, our House of Delegates must lay careful grounds for our policies of the future. Our soldier confreres must come home to us with a knowledge that we have planned for the future, theirs and ours. We must preserve for them the things that they cherish here at home as they are fighting there to preserve things that we cherish.

The sessions of the House of Delegates are open to all members of the Association. All who can possibly do so should attend as observers, so to be informed of developments as they arise.

All delegates should plan to be present at whatever personal sacrifice that is necessary.

Respectfully submitted,

E. VINCENT ASKEY, *Speaker.*

REPORT OF THE VICE-SPEAKER

To the President and the House of Delegates:

"Sweet are the uses of adversity,
Which like the toad, ugly and venomous,
Wears yet a precious jewel in his head."—*Shakespeare.*

The most important event in the past twenty years of California Medical Association history occurred when the House of Delegates at its special session the first week in January adopted a positive, unequivocal, aggressive policy in support of the private practice of medicine and in favor of the voluntary principle as applied to the prepayment of the costs of illness.

By this action, the House reflected the opinions of an overwhelming majority of our membership. It served notice upon the people of this State that we as an organization are thoroughly aware of the multitude of panaceas urged or employed to relieve every social and economic evil, and that we will not be a party to appeasement in any form in dealing with the most serious of these fallacies, compulsory health insurance.

The House of Delegates by this forthright and courageous action further emphasized to the people of this State that Organized Medicine has done an excellent job in its field; that it has taken in the past and will take in the future an active part in making its services more readily available to all who need them; that the costs of such services can be properly prepaid on a voluntary basis, and that such a plan is the American solution of an American problem.

Such a stand by the House of Delegates should be a battle call to every member of the California Medical Association who believes in the practice of his art and profession, and who above all else, believes in sound representative government. The fight will be hard, but it can be won.

Respectfully submitted,
L. A. Alesen, *Vice-Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

During 1944 it has been my privilege to preside at the meetings of the Council. On another page you will find a tentative report of the Council. Perusal of this report will serve to inform you—many of you already are aware of this—that the past year has been productive of many important items and serious problems confronting the Association. Additional reports and recommendations may be made by the Council for consideration by the House of Delegates.

Respectfully submitted,
P. K. Gilman, *Chairman of the Council.*

REPORT OF THE COUNCIL

To the President and the House of Delegates:

1. Meetings.

During the year 1944 the Council of the California Medical Association held 7 meetings, the same being meetings 314 to 321, inclusive, as of the following dates: January 23; March 5; May 6; May 7; May 8; August 6; and December 13.

The proceedings of the various meetings were printed in California and Western Medicine in the following issues: March, page 101; April, page 213; June, pages 323-327; September, page 151; and January, 1945, page 26.

Members who have taken the trouble to peruse the above minutes could not be otherwise than impressed with the importance of the problems considered, even though some have not as yet been possible of solution. In these matters the Council, as the constituted authority of the Association to act between meetings of the House of Delegates, could only study the various issues and take such action, tentative or otherwise, as at the time seemed best adapted to promote the interests of the medical profession.

2. Membership.

On January 1, 1944, the California Medical Association was credited with a membership of 7,336 doctors of medicine (civilian members, 5,274; military members, 2,062). On December 31, 1944, the total membership was 7,627, an increase of 291 members for the calendar year 1944 (civilian members, 5,453; military members, 2,174) The total number of members who died during the year was 84.

3. Finances.

Concerning the financial status of the Association, members are referred to the report of the Secretary-Treasurer, wherein the audit of the Certified Public Accountants is given, and the report of the Executive Secretary, who makes comment concerning the income and expenses of the Association as carried on through his office.

4. Public Opinion Survey Re: Medical Profession.

In January, 1944, the firm of Foote, Cone and Belding, through its representative, Mr. John R. Little, submitted a 232-page report, "Survey of Public Relations of the California Medical Profession as of January, 1944." An "Interpretative Report" of the above was printed in California and Western Medicine for May, 1944, on page 241. This survey indicated the desire of the California Medical Association to secure accurate information, not only concerning the adequacy of medical service in California, but also the opinions of citizens of California in relation thereto. The information received was of real value and has received much consideration and comment, both in California and other parts of the United States.

5. Western States Public Health League (United Public Health League).

The action of the Council of the California Medical Association some years ago in presenting to the House of Delegates of the American Medical Association a resolution to have the American Medical Association establish an A.M.A. Bureau of Medical Economics may be cited to show the wish of the medical profession of California to bring about in the Nation and in the States and local areas, a better understanding of the medical economic problems that were increasingly coming to the front. As a result of that resolution, the American Medical Association did establish as one of its activities, the A.M.A. Bureau of Medical Economics. Unfortunately, that Bureau seemed rather to have had as its major objective the elaboration of statistical and informative data, rather than of becoming an active and militant agency through which constituent State medical associations and their component county units could not only secure information, but be able to work to better advantage against legislation inimical to the best interests of the public health.

Last year, the C.M.A. Council felt, since important issues adverse to the best standards and interests of the medical practice were developing so rapidly, and the A.M.A. Bureau of Medical Economics had not shown adequate leadership capacity, it was proper for the California Medical Association to aid in the promotion of some other agency that would consider the immediate problems ahead, and through a properly setup bureau, devise ways and means that would make for a better protection of medical service and health standards than under the arrangement noted above.

To that end, at the meeting of the Council on January 23, 1944, the Council allocated the sum of $18,000.00 in support of an organization that had come into being among some of the Far-West constituent state medical associations, the affiliation organizing under the name "Western States Public League." Through this newly formed collateral organization, now operating under the name "The United Public Health League," an office has been established in Washington, D. C., with a personal representative in charge. Component county societies have received bulletins from this organization and are, therefore, somewhat familiar with its work. Without evidence of over-pride in regard to this newly formed agency, it may be stated that it is the belief of many physicians that the institution of a Washing-

ton, D. C., office with a representative of "The United Public Health League," has had a decided influence in bringing about at long last, a similar office by the more recently formed Council on Medical Service and Public Relations of the American Medical Association (into which the A.M.A. Bureau of Medical Economics has been absorbed).

It is possible that the present House of Delegates of the California Medical Association may wish to express itself concerning the future support and activities of the "United Public Health League," since continued financial appropriation should now have the sanction of the C.M.A. House of Delegates.

6. Liaison Committee on Medical and Hospital Plans in California.

The good will of the California Medical Association in relation to projects designed to bring about a kindly relationship between medical and hospital authorities and agencies is evidenced through the appointments of a Committee of Eight, a Committee of Ten, and finally, a Committee of Six. Through these groups, each one succeeding the other, efforts have been made to bring about a cordial understanding and affiliation of the organizations represented.

California is a large State, not only geographically, but in its diverse metropolitan, agricultural and other environments. Plans for organizations designed to give "hospitalization service" on a prepayment basis came into being before the California Medical Association instituted its own collateral "medical service" organization, through a corporation operating as "California Physicians' Service." Each of the three hospitalization groups, "Intercoast" with headquarters at Sacramento; "Hospital Service of California" with major headquarters in Oakland, and "Hospital Service of Southern California" with main office in Los Angeles, is listed as a member of the Blue Cross hospitalization setup, and each of these three hospitalization groups has built up for itself a considerable reserve in funds.

California Physicians' Service, designed originally to provide, on a prepayment basis, medical service on a fee-for-service plan, began operation at a later date, some six years ago.

It is unfortunate that the differences that have arisen in scope of functions and areas to be covered in hospitalization and medical services could not have been satisfactorily adjusted before now.

Additional information concerning the problems involved may be gleaned from perusal of the report by the Chairman of the C.M.A. Liaison Committee of Six.

7. Malpractice Insurance Premiums.

Owing to some unfortunate experiences arising in one or two areas in California, and due largely during the last several years to the negligence of non-medical assistants, judgments for malpractice were handed down by the California courts that ran into some hundreds of thousands of dollars. In order to recover from their financial losses the commercial carriers involved found it necessary to raise their premium charges for malpractice coverage in rather heavy amount.

Ways and means to bring about a betterment of this particular problem have been a subject of close study by the C.M.A. Committee on Medical Defense, and elsewhere reports thereon will be submitted for the consideration of the Delegates.

8. Permanente Foundation Hospital.

At several meetings of the Council, reports were made concerning the Permanente Foundation Hospital located in Oakland. At one time this organization, dealing almost exclusively with workers in wartime shipbuilding and related industries, had wage charge-off membership for about 100,000 workers. That particular plan has received much press and other exploitation, and special comment was made thereon in California and Western Medicine for October, 1943.

A Council Committee made report concerning the Kaiser Foundation Hospital in California and Western Medicine for March, 1944, on page 104, item 9.

At the time this report is written, it is in order to mention a press announcement that the Permanente Foundation Hospital has proclaimed its intention to presumably give medical service not only to workers, but to families of workers. By indirection it may be said that this organization has been able to develop its massive building construction and other programs largely as a result of indirect governmental aid. As pointed out by the special Council Committee, it is very proper to inquire what are the future objectives of this organization (that seemingly operates under an indirect governmental subsidy), in relation to civilian medical service plans of the future?

9. Agricultural Workers Health and Medical Association.

Mention is here made of the difficulties encountered during the last session of the United States Congress through proposed laws whereby much of the efficient medical service given to migratory workers in agriculture could have been destroyed. The Council's Committee has made every effort to maintain the efficiency of the splendid organization that came into being, largely through the advice and work of Past-president Karl L. Schaupp.

10. California and Western Medicine.

As stated in the report of the Editorial Board and Editor of California and Western Medicine, it was found necessary during the last year to change printers.

The newsprint conservation plan of the Federal Government continues, on which account it has not been possible to increase the number of pages allotted to original articles. The important issues involved in proposed sickness insurance legislation have necessitated the allocation of much space to those very important issues.

In order to make possible the presentation of a larger number of scientific articles, the Council has authorized the use of a smaller eight point type. Also, in due time when opportunity permits, additional clerical help will be provided in the editorial office to permit better filing of manuscripts and other work on related matters.

11. Industrial Accident Commission Fee Table.

Attention has been called by the Council to the efforts that have been made to bring about a more adequate fee schedule for medical and surgical fees in industrial compensation cases. During a period of some twenty-five years the minimum fee table originally established to aid in the institution of the industrial compensation plan in California has been practically ignored, so far as authorization for adequate increase in compensation for medical and surgical services is concerned. In the meantime, refund dividends on premiums to policy holders have been granted in the amount of millions of dollars. The efficiency of State compensation protection of workers depends in large part upon the kind of service rendered by members of the medical profession. It is, therefore, proper that continued effort should

be made to bring about a proper readjustment in professional fees. Additional information may be found concerning the steps that have been taken in this matter, in the report of the Legal Counsel.

12. C.M.A. Delegates to the American Medical Association.

Because of unhappy conditions which had arisen in relation to the representation of the California Medical Association in the House of Delegates of the American Medical Association, a number of C.M.A. Delegates submitted their resignations to the C.M.A. House of Delegates in May, 1944.

In order to better orient C.M.A. Delegates with the actions of the Council of the California Medical Association, the Council has voted that the C.M.A. Delegates shall meet with the Council at one or two meetings prior to the Annual Session of the A.M.A. House of Delegates. Members of the Association are invited to send in suggestions for the consideration of the C.M.A. Delegates.

13. Osteopathy in California.

In last year's report reference was made to the efforts designed to bring about a betterment of relationship between Doctors of Medicine and osteopathic physicians and surgeons in California. For a time it was thought progress was being made, because of informal opinions expressed by the Council on Medical Education of the American Medical Association and of the Board of Trustees of the Association of American Medical Colleges. However, at a later date word was received that the National Federation of Examining Boards objected to the plans proposed; and because the A.M.A. Council and the Association of American Medical Colleges could not jeopardize licensure of graduates from institutions recognized by their respective bodies, it was necessary to drop the negotiations.

14. Proposal to Lower Medical Licensure Laws in California.

Under the above caption, California and Western Medicine in its issue of October, 1944, called attention to proposals of the Committee on Postwar Medical Service made at a meeting in New York City on September 9, 1944, whereby request was made of the medical profession that amendments be made to medical practice acts in the various commonwealths, whereby a temporary license (without examination) would be given to an honorably discharged medical officer of the Armed Forces, and also to a physician in civilian practice, if the applicant presented satisfactory evidence that he had "rendered medical service during the period 1940-1945 in industry or in a civilian community." The members of the C.M.A. Council went on unanimous record in opposition to the suggestion made by the Committee on Postwar Medical Service. One of the addresses at the general session will be by a representative of the California State Board of Medical Examiners, and it is hoped further information will be given concerning existing problems in licensure, which for the State of California, have quite different aspects than those presented in other commonwealths of the Union.

15. California Physicians' Service.

Reference has been made above to the plans to bring about a closer coöperation between the three Blue Cross hospitalization groups operating in California and the nonprofit medical service corporation, California Physicians' Service, brought into being by the California Medical Association. The California Medical Association established this Statewide prepayment medical service plan some six years ago, at a time when there was little actuarial or other background available as guideposts for procedures. Naturally, some errors in procedure were made, but these, one by one, have been rectified as time went on, as far as has been possible.

At its session last year, the House of Delegates for the first time went into recess and resolved itself as the Board of Administrative Members of C.P.S., and in that capacity elected the Board of Trustees of C.P.S. California Physicians' Service, as a corporation, must abide by the corporate laws of the State, and its administration must be carried on from the Board of Trustees down.

Many suggestions were submitted concerning desirable changes and, insofar as possible, these have been made. Despite the many efforts made, it has not been possible to secure an over-all administrative chief for C.P.S. Rather than to commit an error through an undesirable appointment, it was deemed wise to wait until the proper individual could be found.

The report of California Physicians' Service, as given in the "Pre-Convention Bulletin," presents additional information concerning the present status of the organization which, in recent months has received much publicity, in connection with the sickness insurance bills presented to the California Legislature, which convened in January, 1945.

16. Proposed Prepayment Sickness Insurance Laws.

On December 13, 1944, Governor Earl Warren met with members of the C.M.A. Council and other representatives of the California Medical Association and outlined legislation which he stated he would propose, for a compulsory sickness insurance system to become operative in California. The report of that meeting was given in California and Western Medicine in its issue of January, 1945, on pages 26-28.

So important were the issues involved that the Council on that date issued a call for a special session of the House of Delegates of the California Medical Association, which was held in Los Angeles on January 4-6, 1945.

At the three-day session of the House of Delegates, before which representatives of labor and other groups made addresses, the issues were discussed in considerable detail, the resolutions that were finally adopted being printed in California and Western Medicine for January, 1945, on pages 32-34.

In subsequent issues of the Official Journal extensive comments have been made concerning the progress of the various bills that were submitted to this year's 56th California Legislature.

Digests of the compulsory sickness insurance C.I.O. bill, A.B. 449; Governor Earl Warren's compulsory sickness insurance bill, A.B. 800; and the voluntary sickness insurance bill of the California Medical Association, A.B. 1200, appeared in California and Western Medicine for February, 1945, on pages 89-92.

At the time this report is written, hearings are being held on these various bills. No further comment is here made, since other reports will be submitted to the House of Delegates by the C.M.A. Committee on Public Policy and Legislation and other officers and affiliated groups.

* * *

In closing this report for the C.M.A. Council, it is desired to call to the attention of all practicing physicians of California, and to members of the California Medical Association, the grave importance of the issues now being discussed in the public forums and press,

concerning medical practice procedures. These could made radical changes for the future, should some of the proposed legislation be enacted by the Legislature and signed by the Governor, or perhaps referred to the voters of the State in a referendum, or be submitted in the November, 1946, general election in the form of initiative laws.

Respectfully submitted,
THE COUNCIL OF THE CALIFORNIA
MEDICAL ASSOCIATION,
PHILIP K. GILMAN, *Chairman.*

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

To the President and the House of Delegates:

The function of the Board of Trustees is to hold in trust the monies and properties of the California Medical Association. During the past year the Board of Trustees has met regularly and has transacted the necessary business of the Association. The report of its activities and the state of the financial affairs of the Association is included in the report of the Treasurer.

Respectfully submitted,
LOWELL S. GOIN, *President.*

REPORT OF THE SECRETARY-TREASURER

To the President and the House of Delegates:

In accordance with past custom, your Secretary-Treasurer submits his report under two subheadings: (1) Report of the Association Secretary, and (2) Report of the Treasurer.

I. Report of the Association Secretary

The work of the Association Secretary has to do with his activities for the constituted authorities of the C.M.A., as outlined in the Constitution and By-laws; namely, House of Delegates, Council, Executive Committee, Committee on Scientific Work, Committee on Postgraduate Activities, Committee on History, as well as with general correspondence with other state medical societies, and with members of the Association and others.

With the limited amount of clerical help available, it has been difficult, at times, to turn out all work promptly. Meetings of the constituted bodies of the Association also imply special work, not only in preparation of agenda, but on occasion, need much follow-up attention to carry out instructions concerning actions taken.

Appreciation is expressed to all who have aided in the performance of these various duties.

II. Report of the Treasurer

The C.M.A. Constitution provides that the person who is elected to the office of Secretary-Treasurer must hold the degree of Doctor of Medicine. In such capacity the undersigned submits: (a) the Original Budget approved by the House of Delegates (in 1943) for the calendar year 1944, and (b) the Report of the Certified Public Accountants (Messrs. Hood and Strong of San Francisco).

Concerning the collection and disbursement of funds of the Association, these functions, by Council action, have been delegated to the Executive Secretary as part of his responsibilities, and in his report, comment thereon will be made.

In scanning the report of the Certified Public Accountants, it is important for members to keep in mind that the funds of the California Medical Association are kept under two separate authorities: (1) Current maintenance and administrative income and expenses, presented under the heading, "California Medical Association"; and (2) Reserve funds; given under the title, "Trustees of the California Medical Association," a nonprofit corporation composed of the year-by-year general officers, whose members in that organization function as a holding company for the California Medical Association, in compliance with the corporate laws of the State. From time to time, the C.M.A. Council transfers excess funds to the "Trustees of the California Medical Association." Also, when occasion demands, the C.M.A. borrows from the "Trustees."

The financial records of the Association are on file in the headquarters office, should additional information be desired.

Respectfully submitted,
George H. Kress, *Secretary-Treasurer.*

Budget for Calendar Year 1944

CALIFORNIA MEDICAL ASSOCIATION
(As adopted by House of Delegates in 1943)

Income

Membership Dues	$ 80,000
Advertising Sales	25,000
Journal Subscriptions	500
Reprint Sales (Net)	100
Annual Session	
Miscellaneous (includes earned interest, Herzstein Bequest, etc.)	1,500
TOTAL REVENUES	$107,100

Expenditures

Rent	$ 3,288
Telephone and Telegraph	750
Postage	750
Stationery and Printing, Office Supplies, Office Expense	2,000
Salaries:	
(a) Secretary-Treasurer	3,600
(b) Executive Secretary	7,600
(c) Clerical	8,500
(1) Social Security Tax	1,040
(2) Unemployment Tax	520
Travel Expenses:	
(a) Officers	750
(b) Councilors	2,500
(c) Executive Committee	250
(d) Secretary	500
(e) A.M.A. Delegates	2,500
Council-Executive Committee Expense	400
Annual Session	6,000
Employee's Annuities	500
Pensions	960
Dept. of Public Relations	8,214
Cancer Commission	1,000
Committee's Expenses	1,500
Committee on War Effort	2,000
Postgraduate Committee	2,000
Public Policy and Legislation	13,500
Benevolence Committee	5,000
Secretarial Conference	1,000
Donations to Libraries	2,000
Legal Department	5,500
Woman's Auxiliary	200
Equipment Expense	400
Miscellaneous	3,000
California and Western Medicine:	
(a) Printing	17,000
(b) Postage and Mailing	1,500
(c) Advertising Commissions	5,000
(d) Discount and Collections	250
(e) Editor's Salary	4,000
(f) Supplies	450
(g) Postage	750
(h) Illustrations	600
(i) Doubtful Accounts	250
(j) Addressograph Expense	300
(k) Editorial Board Travel	300
TOTAL EXPENSES	$118,122

* * *

Report of the Certified Public Accountants, Hood and Strong, San Francisco, follows:

Report of Examinations

* * *

I. California Medical Association and of II. Trustees of the California Medical Association (A Corporation)

San Francisco, California
December 31, 1944

I

California Medical Association
HOOD AND STRONG
CERTIFIED PUBLIC ACCOUNTANTS
SAN FRANCISCO

No. 1036-1544 January 22, 1945

California Medical Association, San Francisco.
Dear Sirs:

Pursuant to your instructions, and following upon our similar attention for previous years, we have made an examination of the accounts and records of California Medical Association for the year ended December 31, 1944, and present hereinafter the following statements:

California Medical Association and Trustees of the California Medical Association (a Corporation):—
Combined Comparative Balance Sheet—December 31, 1944 and December 31, 1943
California Medical Association:—
Balance Sheet—December 31, 1944
Statement of Income and Expenditure—Comparative for Years Ended December 31, 1944 and December 31, 1943
Expenditure—Comparative for Years Ended December 31, 1944 and December 31, 1943

We have also made an examination of the accounts of the Trustees of the California Medical Association, a non-profit corporation, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing in the statements herein submitted, and indicate, generally, the scope of our examination:

Combined Comparative Balance Sheet
December 31, 1944 and December 31, 1943

California Medical Association and Trustees of the California Medical Association (A Corporation)

This statement exhibits, in condensed form, the combined assets and liabilities of both organizations. The assets and liabilities of the California Medical Association will be discussed in detail hereinafter, and a separate report is being presented as to the assets and liabilities of the Trustees of the California Medical Association (a corporation).

Balance Sheet—December 31, 1944
California Medical Association
Assets

CASH—$73,702.30:

We verified the amounts on deposit in banks from the basis of confirmations received by us directly from the depositaries. The petty cash fund was counted.

ACCOUNTS RECEIVABLE—$2,283.48:

These consist of "California and Western Medicine" advertisers, in amount $2,783.48, less a reserve of $500.00 which has been provided for doubtful accounts. These accounts are considered to be collectible in the ordinary course of business. We examined accounts totaling the above sum, but we did not verify the amounts by direct correspondence with the individual debtors.

TRUST FUNDS—$9,839.88:

These consist of (a) the Morris Herzstein Bequest Fund of $2,546.38, and (b) the Benevolence Fund of $7,293.50.

(a) The changes in the Herzstein Bequest Fund during the year were as follows:

Balance, December 31, 1943	$1,848.86
Add Interest	21.34
Bequest from Trustees of Fund	676.18
Balance, December 31, 1944	$2,546.38

The income was verified from a photostatic copy of a statement of receipts and disbursements by Wells Fargo Bank & Union Trust Co., Trustee, as to the bequest, and the savings bank interest was verified from the pass-book.

(b) The change in the Benevolence Fund during the year is as follows:

Balance, December 31, 1943	$ 5,524.50
Transfer from Commercial Account, as authorized by Council	5,369.00
	$10,893.50
Less Disbursements—Los Angeles County Physicians Aid Association	3,600.00
Balance, December 31, 1944	$ 7,293.50

Disbursements were verified from the basis of canceled checks and the balance was confirmed directly to us by the bank.

DEFERRED CHARGES—$1,051.88:

Details of this asset appear on the Balance Sheet and call for no further comment, and, in our opinion, are correctly stated.

* * *

Liabilities

ACCOUNTS PAYABLE—$2,701.60:

The composition of this item appears on the Balance Sheet and we are satisfied that it is correctly stated.

TRUST ACCOUNTS—$9,839.88:

This is a contra item to the amount of like assets shown in the Balance Sheet under Assets, and has been commented on hereinbefore.

SURPLUS—$73,677.06:

This is the amount by which the total assets exceed the total liabilities at December 31, 1944. The only changes during the year are the addition of the net receipts over disbursements, and the cancellation of a reserve of $39,300.00 which had been provided in prior years against possible loss on the amount advanced to California Physicians' Service. In 1944 this advance was paid in full, and the reserve therefor was canceled.

Statement of Income and Expenditures

This statement is presented in comparative form for the years 1944 and 1943, together with increases or decreases in the various items. We checked the membership dues to the statement of remittances sent in by County Societies, and further verified them by direct correspondence with several of the County Societies selected by us at random, asking them to confirm to us the amount remitted by them. The income was verified to have been deposited in banks.

From the basis of our examination and from replies received from County Societies, we are satisfied that dues are being properly received and accounted, although, as understood by you, we made no attempt to check the dues to the membership cards on file.

Income from advertisements in the "Journal" was test-checked by us to advertisements appearing in the December, 1944, issue of that periodical. It has been the practice to allocate to Income of the "Journal" $3.00 per member whose dues were paid for the entire year and $1.50 per member for those who joined the Association after July 1.

In 1943 in making this allocation, the "Journal" was credited with income on the basis of the entire membership, including those members who were in military service, even though dues to these members were waived. In 1944, however, the "Journal" was credited with income only of those members who paid dues. This accounts for the large reduction in amount of income credited to the "Journal" from dues in 1944 under 1943.

Expenditures were verified from canceled checks and by inspection of vouchers, where necessary.

Minutes of the meetings of the Council, Directors, etc., were reviewed by us for authorization of expenditures, where necessary. The following amounts not appropriated in the original budget for 1944 were expended and these were verified by us to have been properly approved:

	Original Budget	Increased Expenditure
Salary—Secretary-Treasurer	$3,600.00	$ 325.00
Salary—Executive Secretary	7,600.00	933.32
Department of Public Relations	8,214.00	8,364.00
United Public Health League	0.00	18,000.00
Department of Public Relations (California Physicians' Service)	0.00	25,000.00

We are submitting a Comparative Statement of Expenditures for the years 1943 and 1944 in detail, showing the increases or decreases in the various items, all of which appear to be self-explanatory.

Very truly yours,

(Signed) HOOD AND STRONG.

* * *

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

BALANCE SHEET
December 31, 1944

ASSETS			
Cash		$73,702.30	
On Deposit	$73,653.30		
Commercial Accounts	$43,391.42		
Savings Accounts	30,261.88		
Petty Cash Fund	49.00		
Accounts Receivable		2,283.48	
Journal Advertisers: Total	2,783.48		
Less Reserve for Doubtful Accounts	500.00		
Trust Funds		9,839.88	
Morris Herzstein Bequest	2,546.38		
Benevolence	7,293.50		
Furniture and Fixtures—Nominal Value		1.00	
Deferred Charges		1,051.88	
Rent Paid in Advance	274.00		
Equipment for Annual Meeting	133.42		
Postage	644.46		$86,878.54
LIABILITIES			
Accounts Payable		2,701.60	
Journal Production—Accrued Expense	2,179.79		
Miscellaneous	521.81		
Deferred Income		660.00	
Dues Received in Advance	660.00		
Trust Accounts		9,839.88	
Unexpired Balance of Income Received under Herzstein Bequest	2,546.38		
Benevolence Fund	7,293.50		13,201.48
Surplus			$73,677.06
Representing the amount by which the total Assets exceed the Liabilities as of December 31, 1944:			
Balance, Jan. 1, 1944		23,754.44	
Add		49,922.62	
Transfer from Reserve (Note Paid)	39,300.00		
Excess of Receipts over Disbursements for year 1944	10,622.62		

STATEMENT OF INCOME AND EXPENDITURE
COMPARATIVE FOR YEARS ENDED
DECEMBER 31, 1943 AND DECEMBER 31, 1944

	YEAR ENDED DECEMBER 31, 1944	YEAR ENDED DECEMBER 31, 1943	INCREASE *Decrease*
DUES AND GENERAL:			
Membership Dues — Less portion allocated to Journal Subscriptions	$ 93,770.00	$ 85,188.13	$ 8,581.87
California Medical Society—Services	600.00	600.00	
Interest Earned	349.37	272.73	76.64
Miscellaneous		2.74	*2.74*
	$ 94,719.37	$ 86,063.60	$ 8,655.77
OFFICIAL JOURNAL, "CALIFORNIA AND WESTERN MEDICINE":			
Advertising	$ 33,477.42	$ 28,661.05	$ 4,816.37
Members' Subscription (Allocated from Dues)	16,160.00	21,771.00	*5,611.00*
Cash Subscriptions	1,044.53	825.80	218.73
Reprint, Sales, Etc.	31.20		31.20
	$ 50,713.15	$ 51,257.85	*$ 544.70*
Total Income	$145,432.52	$137,321.45	$ 8,111.07
EXPENDITURE			
ADMINISTRATIVE	$ 60,668.62	$ 46,581.45	$14,087.17
SCIENTIFIC EDUCATION AND PUBLIC RELATIONS	40,541.23	22,929.76	17,611.47
OFFICIAL JOURNAL, "CALIFORNIA AND WESTERN MEDICINE"	33,600.05	30,822.73	2,777.32
TOTAL EXPENDITURE	$134,809.90	$100,333.94	$34,475.96
EXCESS OF RECEIPTS OVER DISBURSEMENTS	$10,622.62	$ 36,987.51	*$26,364.89*

* * *

CALIFORNIA MEDICAL ASSOCIATION
EXPENDITURE
COMPARATIVE FOR YEARS ENDED
DECEMBER 31, 1944 AND DECEMBER 31, 1943

	YEAR ENDED DECEMBER 31, 1944	YEAR ENDED DECEMBER 31, 1943	INCREASE *Decrease*
ADMINISTRATION:			
Salary — Association Secretary and Treasurer	$ 3,825.00	$ 3,600.00	$ 225.00
Salary — Executive Secretary	8,533.32	7,366.67	1,166.65
Salaries—Clerical	8,141.26	7,641.16	500.10
Travel Expense:			
Secretary	561.76	521.29	40.47
Officers		81.58	*81.58*
Council	2,455.96	3,206.52	*750.56*
Executive Committee		126.73	*126.73*
A.M.A. Delegates	2,122.75	1,865.28	257.47
Taxes—Payroll	348.82	272.88	75.94
Annual Meeting Expense	5,407.30	5,873.06	*465.76*
Legal Expense:			
Retainer Fee	4,000.00	4,000.00	
Other Legal Expense	944.59	1,025.65	*81.06*
Rent	3,288.00	3,288.00	
Office Supplies and Expense	1,312.16	1,877.21	*565.05*
Postage	726.23	526.43	199.80
Telephone and Telegraph	687.83	673.06	14.77
Council and Executive Committee	726.52	652.00	74.52
Equipment Expense	105.60	189.66	*84.06*
Miscellaneous	2,116.79	2,294.27	*177.48*
Survey — California Medical Service and Hospital Organizations		1,500.00	*1,500.00*
Contribution to the United Public Health League	15,364.73		15,364.73
	$ 60,668.62	$ 46,581.45	$14,087.17

SCIENTIFIC, EDUCATIONAL AND PUBLIC RELATIONS:			
Contributions to Medical Libraries	$ 2,745.00	$ 2,666.00	$ 79.00
Public Policy and Legislation Expense	12,028.01	11,201.67	826.34
Other Committee Activities	2,183.12	3,316.29	*1,133.17*
Department of Public Relations	8,388.95	416.80	7,972.15
Department of Public Relations, C.P.S. Promotion	9,698.15		9,698.15
Physicians' Benevolent Committee	5,498.00	5,329.00	169.00
	$40,541.23	$ 22,929.76	$17,611.47
OFFICIAL JOURNAL—"CALIFORNIA AND WESTERN MEDICINE":			
Salary — Editor	$ 4,249.97	$ 4,000.00	$ 249.97
Printing	20,441.06	19,411.58	1,029.48
Advertising Commissions	4,368.04	3,908.72	459.32
Wrapping and Mailing	2,053.26	1,579.03	474.23
Illustrations	282.80	374.85	*92.05*
Supplies, Expense and Office Postage	1,805.21	1,116.31	688.90
Discounts and Collection Expense	399.71	432.24	*32.53*
	$ 33,600.05	$ 30,822.73	$ 2,777.32
TOTAL EXPENDITURE	$134,809.90	$100,333.94	$34,475.96

* * *

II

Trustees of the California Medical Association (A Corporation) Report of Examination December 31, 1944

No. 1035-1544 January 22, 1945

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION),
San Francisco,
California.

Dear Sirs:

Pursuant to your instructions, and following our attention for prior years, we have made an examination of your accounts for the year 1944, and upon the conclusion thereof, have prepared and present hereinafter the following statements:

Trustees of the California Medical Association (a Corporation) and California Medical Association:—
Combined Comparative Balance Sheet—
December 31, 1944 and December 31, 1943
Trustees of the California Medical Association (a Corporation):—
Balance Sheet—December 31, 1944
Statement of Income and Expenditure—
Comparative for the Years Ended December 31, 1944 and December 31, 1943

We have also made an examination of the accounts of California Medical Association, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing in the statements submitted herein, and indicate, generally, the scope of our examination:—

Trustees of the California Medical Association (a Corporation) and California Medical Association
Combined Comparative Balance Sheet—
December 31, 1944 and December 31, 1943

This statement exhibits, in condensed form, the combined assets and liabilities of both organizations. The assets and liabilities of the Trustees of the California Medical Association will be discussed in detail hereinafter, and a separate report is being presented as to the assets and liabilities of the California Medical Association.

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION) BALANCE SHEET—DECEMBER 31, 1944

ASSETS

CASH—$5,768.97:

This amount was verified from the basis of a certificate received by us directly from the depositary.

* * *

INVESTMENTS—$92,592.41:

These consist of Government securities of a par value of $92,000.00, plus accrued interest of $592.41, and are stated at cost. Details of these securities are as follows:

*25,000.00 p.v. U.S. Treasury Bonds 4%	—1944-54
5,000.00 p.v. U.S. Treasury Bonds 3⅛%	—1949-52
5,000.00 p.v. U.S. Treasury Bonds 2½%	—1964-69
10,000.00 p.v. U.S. Treasury Bonds 2½%	—1964-69
5,000.00 p.v. War Savings Bonds 2½% 12 yrs.	—Series "G"

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION COMBINED COMPARATIVE BALANCE SHEET

ASSETS	CALIFORNIA MEDICAL ASSOCIATION	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	COMBINED DECEMBER 31, 1944	COMBINED DECEMBER 31, 1943	INCREASE *Decrease*
Cash	$73,702.30	$ 5,768.97	$ 79,471.27	$ 49,132.12	$30,339.15
Marketable Securities		92,592.41	92,592.41	72,270.05	20,322.36
Accounts Receivable	2,283.48		2,283.48	1,890.89	392.59
Endowment Fund		258.15	258.15	255.60	2.55
Benevolence Fund	7,293.50	6,651.78	13,945.28	10,955.70	2,989.58
Trust Fund	2,546.38	51,928.50	54,474.88	52,708.78	1,766.10
Furniture, Equipment, Etc.	1.00		1.00	1.00	
Deferred Charges	1,051.88		1,051.88	790.84	261.04
Note Receivable				39,300.00	*39,300.00*
	$86,878.54	$157,199.81	$244,078.35	$227,304.98	$16,773.37
LIABILITIES, RESERVES AND SURPLUS					
Accounts Payable	$ 2,701.60		$ 2,701.60	$ 2,419.70	$ 281.90
Members' Contribution to Endowment Fund		$ 258.15	258.15	255.60	2.55
Benevolence Fund	7,293.50	6,651.78	13,945.28	10,955.70	2,989.58
Trust Accounts	2,546.38	51,928.50	54,474.88	52,708.78	1,766.10
Deferred Income	660.00		660.00	1,540.00	*880.00*
Reserves				39,300.00	*39,300.00*
Surplus	73,677.06	98,361.38	172,038.44	120,125.20	51,913.24
	$86,878.54	$157,199.81	$244,078.35	$227,304.98	$16,773.37

10,000.00 p.v. War Savings Bonds 2½% 12 yrs.—Series "G"	
20,000.00 p.v. U.S. Treasury Bonds 2½%	—1965-70
12,000.00 p.v. U.S. Treasury Bonds 2½%	—1966-71
$92,000.00	

*Not inspected—in hands of bank for exchange.

All of the above bonds, with the exception of the $25,000 p.v. U.S. Treasury Bonds, were inspected by us at your safe deposit vault in the presence of Drs. Kress and Cline and Mr. Hunton. The $25,000 p.v. Treasury Bonds were in the hands of the bank for exchange, and we examined the receipt from the bank in connection therewith.

* * *

ENDOWMENT FUND—$258.15:

The only change in this account during 1944 was the addition of savings bank interest of $2.55. The balance was confirmed directly to us by the Bank of America, N.T.&S.A. It is offset by a like amount under "Liabilities and Surplus."

* * *

BENEVOLENCE FUND—$6,651.78:

This amount consists of monies in trust for the California Medical Association, and the account was started in 1942, in conformity with the Minutes of the Association. The changes in this account for the year 1944 are as follows:—

Balance, December 31, 1943		$5,431.20
Add		1,220.58
Interest on Savings Account	$ 50.00	
Donation from Women's Auxiliary	1,041.58	
Contribution by Members—		
129 at $1.00	129.00	
Balance, December 31, 1944		$6,651.78

This fund is offset by a like amount under "Liabilities and Surplus."

* * *

TRUST FUND—$51,928.50:

The analysis of this fund is as follows:—

Savings Accounts		$14,573.80
Wells Fargo Bank & Union Trust Co.	$7,073.25	
American Trust Co.	7,500.55	
U. S. Government Securities		37,000.00
Accrued interest to December 31, 1944		354.70
		$51,928.50

The amounts on deposit were verified by us by direct confirmation from the depositaries. The United States Government securities consist of the following:—

$ 5,000.00 p.v. U.S. Treasury Bonds 2¾%	—1945-47
10,000.00 p.v. U.S. Treasury Bonds 2½%	—1949-53
10,000.00 p.v. U.S. Treasury Bonds 2¾%	—March 15,1948
5,000.00 p.v. U.S. Treasury Bonds 2½%	—Dec. 15, 1945
5,000.00 p.v. War Savings Bond 2½% 12 yrs.	—Series "G"
2,000.00 p.v. U.S. Treasury Bonds 2½%	—1966-71
$37,000.00	

These bonds were inspected by us in your Safe Deposit Vault in the presence of Drs. Kress and Cline, and Mr. Hunton. It is our understanding that this fund is an "Indemnity Defense Fund" and is offset by a like amount under "Liabilities and Surplus."

The Trustees have taken out a malpractice liability policy with Underwriters at Lloyds to protect them against any liability of this fund to the extent of $5,000.00 to any one case or a total of $46,000.00. This policy is written for a five year term, expiring January 15, 1945. The changes in this fund during the year are as follows:—

Balance, December 31, 1943			$50,859.92
Add			1,068.58
Bond Interest		$931.46	
Collected during year	$ 757.50		
Accrued, Dec. 31, 1944.	354.70		
	$1,112.20		
Less accrued, Dec. 31, 1943	180.74		
	$ 931.46		
Savings Bank Interest...		137.12	
Balance, December 31, 1944			$51,928.50

* * *

LIABILITIES AND SURPLUS

MEMBERS' CONTRIBUTION TO ENDOWMENT FUND	$ 258.15:
BENEVOLENCE FUND	6,651.78:
TRUST ACCOUNT	51,928.50:

These items are contra to the same funds shown under the assets, and have been discussed in detail hereinabove.

SURPLUS—$98,361.38:

Details of the Surplus appear on the Balance Sheet and call for no further comment. The only change during the year was the addition of Net Income for the year.

STATEMENT OF INCOME AND EXPENDITURE

This has been exhibited in comparative form for the years 1944 and 1943, together with increases or decreases in the various items. We have satisfied ourselves, to the extent practicable, that all Income has been correctly accounted, and that the expenditures are proper.

Very truly yours,

(Signed) HOOD AND STRONG.

* * *

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)

San Francisco, California

BALANCE SHEET DECEMBER 31, 1944

ASSETS

CASH		$ 5,768.97	
On Deposit—Bank of America, N.T.&S.A.:			
Commercial Account.	$ 459.63		
Savings Account	5,309.34		
INVESTMENTS		92,592.41	
U. S. Government Securities	92,000.00		
Accrued Interest	592.41		
ENDOWMENT FUND		258.15	
Bank of America N.T.&S.A.—Savings Account	258.15		
BENEVOLENCE FUND		6,651.78	
Crocker First National Bank — Savings Account	6,651.78		
TRUST FUND		51,928.50	
Savings Accounts	14,573.80		
Wells Fargo Bank & Union Trust Co.	$7,073.25		
American Trust Co.	7,500.55		
U. S. Government Securities	37,000.00		
Accrued Interest to December 31, 1944	354.70		$157,199.81

LIABILITIES AND SURPLUS

MEMBERS' CONTRIBUTION TO ENDOWMENT FUND		$ 258.15	
BENEVOLENCE FUND		6,651.78	
TRUST ACCOUNT		51,928.50	58,838.43
SURPLUS			$ 98,361.38

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)
AND CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

COMBINED COMPARATIVE BALANCE SHEET

ASSETS	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	CALIFORNIA MEDICAL ASSOCIATION	COMBINED DECEMBER 31, 1944	COMBINED DECEMBER 31, 1943	INCREASE *Decrease*
Cash	$ 5,768.97	$73,702.30	$ 79,471.27	$ 49,132.12	$30,339.15
Marketable Securities	92,592.41		92,592.41	72,270.05	20,322.36
Accounts Receivable		2,283.48	2,283.48	1,890.89	392.59
Endowment Fund	258.15		258.15	255.60	2.55
Benevolence Fund	6,651.78	7,293.50	13,945.28	10,955.70	2,989.58
Trust Fund	51,928.50	2,546.38	54,474.88	52,708.78	1,766.10
Furniture, Equipment, etc.		1.00	1.00	1.00	
Deferred Charges		1,051.88	1,051.88	790.84	261.04
Note Receivable				39,300.00	*39,300.00*
	$157,199.81	$86,878.54	$244,078.35	$227,304.98	$16,773.37
LIABILITIES, RESERVES AND SURPLUS					
Accounts Payable		$ 2,701.60	$ 2,701.60	$ 2,419.70	$ 281.90
Members' Contribution to Endowment Fund	$ 258.15		258.15	255.60	2.55
Benevolence Fund	6,651.78	7,293.50	13,945.28	10,955.70	2,989.58
Trust Accounts	51,928.50	2,546.38	54,474.88	52,708.78	1,766.10
Deferred Income		660.00	660.00	1,540.00	*880.00*
Reserves				39,300.00	*39,300.00*
Surplus	98,361.38	73,677.06	172,038.44	120,125.20	51,913.24
	$157,199.81	$86,878.54	$244,078.35	$227,304.98	$16,773.37

Representing the amount by which the total Assets exceed the Liabilities as of December 31, 1944, being—		
Contributed Surplus received from California Medical Association	75,000.00	
Earned Surplus		23,361.38
Balance, January 1, 1944	$21,370.76	
Net Income for Year 1944	1,990.62	

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)
San Francisco, California
STATEMENT OF INCOME AND EXPENDITURE
COMPARATIVE FOR THE YEARS ENDED DECEMBER 31, 1944 AND DECEMBER 31, 1943

	YEAR ENDED DECEMBER 31, 1944	YEAR ENDED DECEMBER 31, 1943	INCREASE *Decrease*
INCOME:			
Interest on Bonds	$2,101.33	$1,967.62	$133.71
Interest on Savings Accounts	46.29	69.17	22.88
	$2,147.62	$2,036.79	$110.83
EXPENDITURE:			
Audit Fee	$ 126.00	$ 126.00	
Miscellaneous	31.00	31.85	.85
	$ 157.00	$ 157.85	$.85
NET INCOME	$1,990.62	$1,878.94	$111.68

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your Executive Secretary submits the following report for the calendar year 1944 and for the early months of 1945:

1. *General.* The Association office has been maintained in the best possible fashion during the period, with due allowance for the fact that certain types of office equipment are required but are not procurable under wartime restrictions. It is obvious that new equipment, particularly typewriters, will be required when purchase restrictions are eased; meanwhile, a policy of adequate maintenance is being followed.

The four office assistants have remained on the job throughout the period, despite the prevalence of outside offers of employment, and the thanks of the Association are certainly due them for a good job well done. Their loyalty and willingness have enabled the office to handle a greatly increased volume of work during a trying period.

2. *Financial.* The Association again operated profitably for 1944. The auditor's report shows that revenues for 1944 were $10,622 in excess of expenditures and that the budgeted items were lived within for the year. Other items, notably expenditures for public relations activities, cut into the surplus which otherwise would have accrued for 1944 but the Association closed the year with a satisfactory cash position and with an accumulated surplus of $73,677, compared with $23,754 a year earlier.

Administrative expenses for 1944 were $45,303, compared with $46,581 for 1943. The Association appropriated $15,365 to the United Public Health League for the year, an item which did not appear on the 1943 accounting. Public relations activities for 1944, notably the Foote, Cone & Belding survey of public opinion and the dissemination of the findings of that study, accounted for expenditures of $17,670, another new item in the C.M.A. income account.

California and Western Medicine was produced at a cost of $33,600 for 1944, an increase from the $30,823 cost for 1943. However, revenues for the 1944 period amounted to $34,553, compared with $29,487 for 1943, resulting in a net profit of $953 for 1944, compared with a net loss of $1,336 for 1943. Production expenses are still rising but revenues are advancing at an even faster rate.

During 1944, California Physicians' Service repaid the balance of the $42,000 loan originally advanced by the C.M.A. These funds, amounting to $39,300, have been placed in Association accounts, with the understanding

that C.P.S. may need a second loan from the Association for some particular purpose at a later date.

The Indemntiy Defense Fund, which represents $52,709 in cash and Government bonds, will be available for distribution late in 1945, at which time a maximum of about $3,500 will be payable to the surviving members of the Fund late in 1945. The freeing of these remaining funds will add to the outright assets of the Trustees of the C.M.A.

3. *California and Western Medicine.* As noted above, the journal returncd a small profit for 1944. During the year the advertising rates were adjusted upward, to reflect the 60 per cent increase in circulation since advertising rates were last set, in 1924. It is a pleasure to report that advertising contracts already on the books for 1945 show a marked increase over 1944 revenues and that the demand for advertising space continues strong. During the past two years there has come a clarification of some of the advertising rules under the control of the Coöperative Medical Advertising Bureau, the A.M.A. affiliate which handles national advertising accounts for California and Western Medicine; this clarification has resulted in the securing of additional business which we have been able to accommodate within our paper stock restrictions. It is hoped that a good portion of this increased business will be retained after the war.

Paper stock restrictions have forced the limitation of our journal in size but the use of a lighter weight paper, together with other economies, has permitted us to maintain our regular format and place minimum restrictions on the publication of editorial material.

4. *Annual Session.* Again in 1944, there were no technical exhibits at the Annual Session. Expenses of this meeting were kept at a minimum, consistent with the standards of quality of these meetings. There will be no exhibits at the curtailed 1945 session. This means that this meeting will again be an expense to the Association, as was the special House of Delegates meeting in January, 1945. These expenses will be reflected in the 1945 year-end accounting.

5. *Procurement and Assignment Service.* The work of this service has dropped considerably in volume and your executive secretary has devoted a smaller percentage of his time to this work than in the preceding two years. The major work of this agency appears to be pretty well completed and it is likely that the Association will be called upon to take over the wind-up stages of this service for the benefit of the profession as a whole. Definite plans in this direction are not yet known.

6. *The United Public Health League.* Your executive secretary serves also as executive secretary of the United Public Health Leaguc. This organization was formed in January, 1944, and has maintained an office in Washington, D. C., since March 14, 1944. This office has been extremely useful in keeping our membership posted on events in the national capital and in holding up to the medical profession of the country the necessity of maintaining a close watch on national legislative events. Future activities of this League will be determined at a coming meeting of the League's directors.

7. *Public Policy and Legislation.* With the California Legislature now in its biennial session and with compulsory health insurance as the major topic in Sacramento, the central office has been called upon for a great volume of work in legislative matters. Your executive secretary has been named as the liaison officer between the Council and the public relations counsel employed by the Association and has devoted much time to appearing at public and private meetings, helping organize Association activities and planning for future moves. This work continues on a heavy scale at this time and will doubtless be with us for some time to come.

8. *Conclusion.* Grateful acknowledgment is hereby made for the gencrous counsel and assistance given the executive secretary by the members of thc Council, thc officers and members of the Association. In any coöperative endcavor such as the C.M.A. teamwork is the most important elemcnt for successful accomplishment, and many members and officers have given unsparingly of their time and help. It is a pleasure to make note of this help and at the same time pay tribute to the offices of our legal counsel and our legislative representatives for their understanding and coöperative assistance at all times.

Respectfully submitted,
John Hunton, *Executive Secretary.*

REPORT OF THE EDITOR

To the President and the House of Delegates:

During the calendar year 1944, major articles which appeared in California and Western Medicine, by groups and number included:

Editorials	41
Editorial Comment Articles	18
Scientific and General (Original) Articles	108
Case Report Articles	4
Major State Association Committee Reports	114
Major Miscellany Department Reports	54

During 1944 the smaller size of California and Western Medicine was maintained in compliance with directives relating to conservation of newsprint paper received from the Federal Government. The Editorial Board made request to the Council that at least one-half of each issue, namely fifty pages, be allocated to text material, and this request, on the basis of yearly totals, was granted by the Council. During 1944, the total number of text pages was 680, an average of 56 2/3 pages per monthly issue. (Inclusive of Tuberculosis Supplement, pp. 43.)

In the November and December issues of 1944, two wartime symposia appeared, and in order to permit publication of a larger number of articles, smaller eight point type was used, instead of the regulation ten point.

No protest having been received from readers concerning this change in size of type, the Editorial Board obtained the sanction of the Council to continue the use of eight point case in the Original Articles section, thus making space available for one or two additional articles each month.

Note may be made here concerning the pages needed for discussions and comment on proposed sickness insurance legislation, necessitating use of space previously allocated to original articles. The reasons for the allocations have received editorial and other comment, and the justification for the change should be self-evident.

In 1944, it was again necessary to change printers. It had been hoped that publication of the Journal in San Francisco would conserve clerical and other work, but such was not the actual experience. Accordingly, the Council authorized change of publication place to Los Angeles, the first issue under the Wolfer Printing Company being that of April, 1944.

For those who may not be acquainted with problems confronting the printing trade, it is proper to state that due to lack of manpower help and other factors, it is not possible during present wartime conditions to bring off publications as promptly as heretofore. Similar delay arises in delivery of journals under second class franks, owing to the limited number of employees in the post office stations.

In the Report of the Committee on Scientific Work, mention is made of a new Council ruling that will apply for the Duration, whereby papers presented at Annual Sessions may be "read by title"; that is, placed on the

program with the author not in attendance. This rule makes every paper on the program of an Annual Session available for publication consideration in CALIFORNIA AND WESTERN MEDICINE.

As stated in previous reports, CALIFORNIA AND WESTERN MEDICINE is an official journal, primarily dedicated to the promotion of organized medicine. The California Medical Association, with its membership of 7,627 Doctors of Medicine, has a multitude of administrative problems and issues intimately related to the economic and other welfare of practicing physicians. If there were no OFFICIAL JOURNAL through which information could be given concerning these matters, it would not be possible to secure adequate coöperation of competent county societies and of members throughout the State, and harm would result for both scientific and organized medicine, and to members individually and collectively.

The large number of journals devoted to medicine, surgery and the specialties, in which the pages are almost entirely given over to scientific articles make it possible for every physician to easily obtain sufficient reading material of that nature. Even so, CALIFORNIA AND WESTERN MEDICINE will continue to make every effort to give as much space as possible to original articles. However, with the limited number of pages permitted by the Government, the space alloted to original articles must be of lesser amount than in previous years.

The Editorial Board again expresses its appreciation to all contributors through whose coöperation it has been possible to present articles and material of value and interest.

Respectfully submitted,

George H. Kress, *Editor.*

REPORT OF LEGAL DEPARTMENT

To the President and the House of Delegates:

In this, the fourth year of the war, we again present our report in condensed form:

Fee Schedule in Compensation Cases:

On February 15, 1943, after a public hearing, the Association's application to the Industrial Accident Commission for the adoption of a compensatory fee schedule, covering all, and not a minor portion of the procedures and operations incident to these cases, was taken under advisement by the Commission. Nothing further occurred officially until June 16, 1944, when the Commission, after a conference with representatives of certain compensation insurance carriers, and officials of the California Inspection Rating Bureau, appointed a Study Committee of ten, composed of representatives of the Commission, the Insurance Commissioner, the Rating Bureau, various types of insurance carriers, and the California Medical Association.

At the same meeting, the fee schedule was increased 15 per cent for the duration. Some of the companies have attempted to claim that this increase was not mandatory, but it was so intended by the Commission and is now generally in effect. Meanwhile, the Study Committee was organized and has held two meetings, Mr. John Hunton, Executive Secretary, representing the California Medical Association.

The objectives of the association in the work of this committee are: (a) the establishing of a fair level of fees for medical services in compensation work; and (b) determining means of enforcing the universal and uniform application thereof.

At the 1943 session of the Legislature, an interim committee on Government Efficiency and Economy was appointed, with Hon. Don Field as chairman, and a subcommittee thereof composed of Assemblyman Albert M. King, chairman, Clyde A. Watson and Frank J. Waters was appointed to investigate the Industrial Accident Commission. This sub-committee held public hearings at San Francisco and Los Angeles, much of its time being concerned with the internal operations of the department. On October 3, 1944, at the Los Angeles Sessions, Dr. Donald A. Cass, John Hunton and Hartley F. Peart, appeared before the committee urging legislative changes with reference to medical service under the act, and compensation therefor, to the end that the injured workmen receive the best quality of medical service, adequate in quantity, and that there be but one standard of medical service rendered to injured workmen throughout the State.

After careful consideration of all factors, a bill, A.B. No. 1702 by Mr. King, chairman of the above mentioned sub-committee, was introduced into the legislature. This bill in substance provides: that the commission shall prepare and adopt and from time to time amend rules and regulations governing medical and surgical service and a fee schedule fixing the reasonable value thereof. That the schedule and rules and regulations shall be reviewed every two years after a public hearing; that no physician or hospital shall rebate to any employer or insurance carrier and that no agreement between an employer or insurance carrier and any other person relating to the measure or amount of compensation for medical, surgical, or hospital care rendered in compensation case shall be enforceable if the charges are less than the reasonable value thereof as fixed by the fee schedule, or unless a copy of such agreement has been filed with the commissioner.

Legislation:

The primary legislative proposals are, of course, the Warren-C.I.O. compulsory state medicine bills. The enactment of any bill establishing any form of compulsory state medicine is so fundamental in its disastrous effect upon medical standards and practice as to subordinate all other legislative issues. Nevertheless the department, as usual, is examining and analyzing some three hundred bills more or less affecting medical practice and standards.

Pursuant to the resolution of the House of Delegates at the special meeting, held in Los Angeles in January, we drafted and submitted to the Executive Committee a bill which was later introduced as AB 1200, sponsored by Assemblymen Collins, Field, Werdel, Erwin, Knight Stewart, Stream and Watson. This bill supports voluntary prepaid medical and hospital plans, and other systems now functioning. It was printed in full in the February 1945 issue of CALIFORNIA AND WESTERN MEDICINE (page 65). Some amendments have been introduced, and this bill is not yet in final form.

Administrative Procedure Act:

The Judicial Council is sponsoring bills in the present session to improve administrative procedure. One of the agencies affected is the State Board of Medical Examiners. These proposals provide for hearing officers, who must be attorneys of several years experience, to pass upon questions of procedure in disciplinary proceedings. Another important subject covered is the judicial review of board decisions.

Appelate Court Decision Confirming Legality of California Physicians' Service:

At the special meeting of the House of Delegates, held at Los Angeles, in December, 1938, we presented two plans of organization for California Physicians' Service, viz.: (1) a medical service plan, and (2) an indemnity insurance plan. After extended debate, the House adopted the service plan.

Thereafter the then Insurance Commissioner challenged the operations of C.P.S. claiming that (1) it was engaged in the insurance business, and (2) it was unlawfully engaged in the corporate practice of medicine.

The case was tried before Hon. C. Julian Goodell, Superior Judge of the City and County of San Francisco, upon a stipulated statement of facts. After briefs and argument, Judge Goodell, on October 28, 1942, decided both of the above contentions in favor of C.P.S.

Thereafter, the Attorney General, representing the Insurance Commissioner, appealed to the Superior Court, which transferred the appeal to the District Court of Appeal of the First District. Extensive briefs were filed. By special permission, a full half day was allowed for oral argument. On February 15, 1945, the District Court of Appeal, comprising Hon. John T. Norse, Presiding Justice, Hon. Geo. A. Sturtevant, Justice, and Hon. Maurice J. Dooling, Justice pro tem, unanimously affirmed the decision of Judge Goodell. In its opinion, the Court quotes with approval from the decision of the Court of Appeals of the District of Columbia in the case of Jordan vs. Group Health Association (107 Fed. 2nd 239). In differentiating between, and defining prepaid medical service and indemnity insurance, this decision states:

"Although Group Health's activities may be considered in one aspect as creating security against loss from illness or accident, more truly they constitute the quantity purchase of well-rounded, continuous medical service of its members. Group Health is in fact and in function a consumer coöperative. The functions of such an organization are not identical with those of insurance or indemnity companies. The latter are concerned primarily, if not exclusively, with risk and the consequences of its descent, not with service, or its extension in kins, quantity or distribution; with the unusual occurrence, not the daily routine of living. Hazard is predominant. On the other hand, the coöperative is concerned principally with *getting service rendered* to its members and doing so at lower prices made psosible by quantity purchasing and economies in operation. Its primary purpose is to reduce the cost rather than the risk of medical care; to broaden the service to the individual in kind and quantity; to enlarge the number receiving it; to regularize it as an every-day incident of living, like purchasing food and clothing or oil and gas, rather than merely protecting against the financial loss caused by extraordinary and unusual occurrences, such as death, disaster at sea, fire and tornado. It is, in this instance, to take care of colds, ordinary aches and pains, minor ills and all the temporary bodily discomforts as well as the more serious and unusual illnesses. To summarize, the distinctive features of the coöperative are the rendering of service, its extension, the bringing of physician and patient together, the preventive features, the regularization of service as well as payment, the substantial reduction in cost by quantity purchasing, in short, getting the medical job done and paid for; not, except incidentally to these features, the indemnification for cost after the service is rendered. Except the last, these are not distinctive or generally characteristic of the insurance arrangement. There is, therefore, a substantial difference between contracting in this way for the rendering of service, even on the contingency that it be needed, and contracting merely to stand its cost when or after it is rendered."

A petition for a rehearing, filed by the Attorney General, was denied. A hearing by the Supreme Court, can, and probably will be applied for.

Opinions:

During the year, perhaps more than the usual number of opinions have been requested, many from members serving with the Armed Forces. In these instances, the questions presented dealt with problems arising in connection with military service, and war activity, questions relating to malpractice such as the use of nurse's aides, and opinions relating to the Office of Price Administration. Among other subjects covered were asexualization, license taxes, libel, various provisions of the disciplinary code; admission of new members; and assessments of medical libraries for local property tax.

We have, as usual, attended all meetings of the Council, the Executive Committee, the Legislative Committee, and other special committees when our presence was desired.

Respectfully submitted,
HARTLEY F. PEART, *General Counsel.*
HOWARD HASSARD, *Assistant General Counsel.*

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

The Societies of District One have succeeded in continuing their scientific programs as usual, in spite of a decrease in attendance due to military requirements.

Great interest has developed in the proposed legislation which would inaugurate state medicine. There is almost unanimous opposition to these proposals.

Respectfully submitted,
H. A. Johnston, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

Your Councilor for the Second District has the following to report for the previous year.

Because of the difficulty of transportation the Council has met only a few times but your Councilor has been present at all meetings.

The meetings held in 1944 were for the most part those which had to do with the regular routine business of the Association and will be covered completely in the report of the Chairman of the Council. However, during this time we had no inkling of the eminence of the threat of Compulsory Health Insurance and the meeting held in December was our first knowledge that the Governor had planned to become a proponant of such a scheme. Since then there have been extra meetings of the Council devoted almost entirely to the question of how to advise the Medical Association relative to problems of Compulsory Health Insurance. The Council is unanimously against endorsing any plan of Compulsory Health Insurance and has pledged itself to carry the mandate of the House of Delegates to the letter.

Your Councilor feels that at the coming meeting of the House of Delegates at its annual convention the problems associated with compulsory health insurance will be met and at that time the House of Delegates will instruct the Council as to what its course will be during the next year.

Respectfully submitted,
Donald Cass, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, Ventura, and Inyo-Mono Counties

To the President and the House of Delegates:

The Third Councilor District has of necessity had to restrict its activities as a district because of wartime conditions. However, each component society is well organized and actively participating in the problems of the medical world. Public forums have been held in each of the counties on numerous occasions as educational efforts directed to the general public. Medical care for the increased population is being adequately met.

Respectfully submitted,
H. E. Henderson, *Councilor,*
Third District.

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mariposa, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

The C.M.A. members of this district are greatly concerned and disturbed by the threatened compulsory health insurance legislation and are quite unanimous in their determination to fight this issue in order to preserve the private practice of medicine and permit the best medical care of our people without regimentation and bureaucratic control. The membership has been urged to tell their patients and friends what it will mean to the public if politicians manage the practice of medicine. An intensive campaign of education of the people of the State is required to avoid disastrous changes in medical care.

For the good of our patients and our future welfare this battle must be won.

Respectfully submitted,

A. E. Anderson, *Councilor, Fourth District.*

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Cruz, and Santa Clara Counties

To the President and the House of Delegates:

The counties of this district have all been vitally interested in the problems that have confronted the C.M.A. this year and have participated in helping to solve these problems.

I have visited or contacted all the counties in my district, and there has been whole-hearted support of the action taken by the House of Delegates.

Meetings were held with representatives of labor in San Mateo County, at which time the members of that district and guests from the adjoining counties had an opportunity to discuss with these representatives the anticipated legislation which has now been introduced by them.

Santa Clara, Monterey and Santa Cruz counties had meetings with their legislators, and they were informed on medicines viewpoint of the legislation now before us.

Much has been done to acquaint the public with the problems that we have in relation to their care. Many meetings have been held with service clubs, political clubs and women's clubs to carry our story to the public.

A great deal has been done in welding the medical profession into a unit so that they will coöperate with one another much better than heretofore, and a united front can now be presented. This should be one of the objectives of all the districts of the State.

Respectfully submitted,

R. S. Kneeshaw, *Councilor, Fifth District.*

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

During the past year, the San Francisco County Medical Society has continued to work under a curtailed scientific program. Most of the activities in direct connection with the war effort, such as the Office of Civilian Defense have been curtailed or terminated.

Many of the problems arising as an indirect result of the war have required time and effort for their solution. The Society has coöperated closely with other agencies in an effort to solve the problems of inadequate hospitalization, diminished nursing and the distribution of medical care. The Society's telephone service for strangers and residents not having regular physicians has worked out quite satisfactorily.

The Irwin Memorial Blood Bank has continued to render excellent service to the community and the surrounding area.

The Society has been greatly concerned over pending legislation which might seriously affect the practice of medicine and presents a more unified front than at any time in its history.

Respectfully submitted,

John W. Cline, *Councilor, Sixth District.*

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

As reported a year ago, there is still a shortage of private hospital beds as well as doctors in my district. While there has been a considerable number of men laid off in the shipyards, the population remains greatly increased.

Since the special meetings of California Medical Association Council in San Francisco on December 12 and 13, 1944, the doctors in the Seventh District have been informed on legislative matters pertaining to the future practice of medicine. I am sure that all of these doctors will coöperate to defeat all compulsory health measures without compromise.

The Alameda County Medical Association has employed Mr. Roland Waterson of Lake County, Indiana, as executive secretary of their association, he will take over his duties next July.

Respectfully submitted,

Lloyd Kindall, *Counellor, Seventh District.*

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties

To the President and the House of Delegates:

During the past year as Councilor of the Eighth District, I have been chiefly concerned with the activities of the Council as a whole, and have attended all regular and special meetings which have been held. I have been unable to visit all the component county societies in this district but have attended meetings of the Yolo, Placer-Nevada-Sierra and Sacramento societies.

The physicians in this district are keenly aware of the recent attempts to regiment medicine, are united in opposition to bureaucratic control, and will coöperate fully to prevent political domination of medical practice.

Respectfully submitted,

Frank A. MacDonald, *Councilor, Eighth District.*

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

The year 1944 was rather uneventful except that the effort to serve the 100,000 people in the Vallejo area has taken our time to such an extent that I have been unable to visit the counties in the northern part of the district. Solano, Napa, Marin and Sonoma counties have all been visiting during the year and since the advent of the possibility of Compulsory Health Insurance, it seems very necessary to visit all the County Medical Societies in 1945 in spite of gas rationing and crowded railway transportaton.

Following the House of Delegates meeting in Los Angeles January 3-4-5, 1945, a special effort was made to contact all the County Societies this side of San Francisco Bay, with a view of implementing the decision of

the House in its mandate to defeat all Compulsory Health Insurance Bills. We are earnestly attempting to carry out the mandate of that body at this time.

Returning to the year 1944: a joint meeting of all the District County Medical Societies was held at Northwood and Guerneville, Calif., on September 24, 1944, under the auspices of the Sonoma County Medical Society. Although the extreme northern part of the State was not represented, there was a good delegation from all the West Bay County groups, including members from Mendocino, Lake, Marin, Napa, Solano, Sonoma and Humboldt Counties. Following a very good dinner, which was preceded by a golf match at the Northwood Golf Club, Dr. D. H. Murray addressed the group and related all the actions of and the program outlined by the Legislative Committee of C.M.A.

Your Councilor has done his best to increase the influence of C.P.S. and continue its activity in the Vallejo district and we are able to report that in spite of influences within the Housing Authority which have attepmted to undermine and discredit the emergency service established by C.P.S. in the area, California Physicians' Service still is carrying on in Chabot Acres Medical Center and serves 12,000 people in accordance with the wishes of that community. Other smaller groups have decided to favor the Stowe-Lipsett medical group of Oakland and a fee-for-service plan. What the ultimate outcome will be, we are unable to report, except to say, that the effort to displace C.P.S. in Vallejo has resulted in an improved attitude of our physicians toward California Physicians' Service and has brought them all to a better understanding of the problems confronting the Medical Profession.

Respectfully submitted,
John W. Green, *Councilor,*
Ninth District.

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

As a Councilor-at-Large of the California Medical Association for the year nineteen hundred forty-four and forty-five, I have attended all of the Council meetings to date.

The year nineteen forty-four and forty-five has been thus far, one of great trouble in many respects. We have had numerous and sundry problems to deal with, the greatest of which has been the question of compulsory health insurance; with several bills passed in to the Legislature by those who, thinkingly or unthinkingly, have their eyes turned to the left.

As this report is written it is my hope, information and belief that all of these bills, too radical for the great majority of the thinking population of the State of California, will have been defeated in the Legislature.

Our next great problem will undoubtedly be to defeat the same or similar bills in November of 1946, when I hope, we will be able to put them down with enough force, that they will not put up their ugly heads again in our time.

The campaign in 1945 and ending November 5, 1946, is going to necessitate every member of the California Medical Association, giving his thought, time, and financal support, to the fight ahead,—in order that those of our confreres returning from the Armed Services, will know that we who remained behind, have not deserted them.

Respectfully submitted
Edwin L. Bruck, *Councilor-at-Large.*

To the President and the House of Delegates:

The past year has been one filled with serious problems to which the council has given long and careful consideration. It has been my privilege to be present at these deliberations and to take an active part in keeping the men in my local community informed.

Respectfully submitted,
Edward B. Dewey, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of your Councilors-at-Large, I have regularly attended the meetings of the Council during the past year, and have attempted to the best of my ability to represent the Council both in public gatherings and various medical meetings where the subject of health insurance was under discussion. I would like to say that from a personal standpoint it has been a privilege to participate in the deliberations of the Council during a delicate and trying period in the history of the California Medical Associaton. It is, in addition, a source of great satisfaction to feel that the important matters which have arisen during the past year have been dealt with wisely and well. It is my belief that the members of the California Medical Association may feel confident that their interests will be safeguarded insofar as it is possible for the officers of the Association to do so.

Respectfully submitted,
Sidney J. Shipman, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of your Councilors-at-Large, I have attended all regular and special meetings of the Council during the year; have visited the majority of the component societies in the First District; and have endeavored to promote coöperation among the organized groups of the District.

Respectfully submitted,
S. J. McClendon, *Councilor-at-Large.*

To the President and the House of Delegates:

I have attended all the meetings of the Council and the House of Delegates and have engaged in all the deliberations and actions of both bodies. The present serious problem of the contemplated Compulsory Health Legislation in this State has seemed for the moment to have superseded the Federal bogey of socialized medicine. Your councilors are keenly aware of this problem and are working diligently, collectively and individually to combat this menace.

Respectfully submitted,
E. Earl Moody, *Councilor-at-Large.*

To the President and the House of Delegates:

During the past year, in my function as Councilor-at-Large, I have endeavored at all times to consider most carefully the many important problems that have presented themselves for decision, and to arrive at a solution that would be for the best interests of the medical profession as a whole.

I have kept my own San Joaquin County Society fully informed as to the problems of organized medicine and legislative activities, and have, as well, reported on the progress and scope of the California Physicians' Service.

Respectfully submitted,
Dewey R. Powell, *Councilor-at-Large.*

All of the animals excepting man know that the principal business of life is to enjoy it.
—Samuel Butler the Younger, *Note-Books.*

It matters not how long we live, but how.
—P. J. Bailey, *Festus: Wood and Water.*

EXECUTIVE COMMITTEE

Executive Group

John W. Cline, Chairman
Lowell S. Goin, President
Philip K. Gilman, President-Elect
E. Vincent Askey, Speaker, House of Delegates
Philip K. Gilman, Chairman of the Council
John W. Cline, Chairman, Auditing Committee
Karl L. Schaupp, Past-President
George H. Kress, Secretary-Treasurer and Editor

To the President and the House of Delegates:

The Executive Committee has met in part or in whole six times during the past year. In the intervals between Council meetings, it has transacted important business for the Council. When only a portion of the membership was present, the remaining members have been informed of actions by mail and their opinions and votes solicited.

All acts of the Executive Committee have been reviewed by the Council, and these actions and their approval have been published in the minutes of the Council

Respectfully submitted,

John W. Cline, *Chairman.*

AUDITING COMMITTEE

Executive Group

John W. Cline, Chairman, 1945
Edwin L. Bruck, 1945 Lloyd E. Kindall, 1945

To the President and the House of Delegates:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association books showed them to have been accurately kept, and the Committee has submitted its recommendations for the 1946 budget.

Respectfully submitted,

John W. Cline, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

To the President and the House of Delegates:

The Committee on Public Policy and Legislation is at present engaged in the most serious and most far-reaching campaign encountered since the present committee has been assembled. The legislation now before the State Legislature, looking forward to possible establishment of a State-controlled system of medical practice, has engaged the entire attention of the committee for the past three months and promises to continue doing so until the Legislature adjourns. An oral report on this situation will be made when the House of Delegates convenes.

The committee has continued the inter-association conferences started four years ago, where representatives the medical, dental, pharmacy, hospital and dispensing opticians' associations get together to discuss legislative trends which may affect one or another of these groups and may impinge on one group from another. Two such meetings have been held in recent months and much valuable coöperation has resulted from them.

A detailed report will be made at the House of Delegates meeting.

Respectfully submitted,

Dwight H. Murray, *Chairman.*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Executive Group

John V. Barrow, Chairman, 1946
Clarence E. Rees, 1945 Anthony B. Diepenbrock, 1947

To the President and the House of Delegates:

The Associated Societies and Technical Groups have worked, this year, as last year, without meetings or consultation with each other. However, we have done our part in the work as associated with the Nursing Association and in whatever way we could be of help to the Woman's Auxiliary.

A great deal of work has been done and accomplished with the Physicians' Aid Association in assisting in the fund to be used for needy doctors as the opportunity offers.

We shall be glad to supplement our report more in detail to the Council at its regular meeting. We are always glad to have work assigned to us directly from the President and Council of the Association.

Respectfully submitted,

John V. Barrow, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

J. C. Geiger, Chairman, 1946
C. M. Burchfiel, 1945 E. Earl Moody, 1947

To the President and the House of Delegates:

Members of the Committee on Health and Public Instruction have held no meetings whatever during the past year.

Several matters, however, all legislative, of great public health interest have developed. The various bills on compulsory health insurance have been studied and are being freely discussed.

Recent months, more than ever before, have seen the development of concentrated interest in and extensive discussion, especially in legislative halls, of the problem of medical care, particularly as to governmental participation in its solution.

American medicine today leads the world, scientifically and in all its humane aspects. Much of the discussion is built around public health and the lack of medical care. Public health, as such, is really not the duty of organized medicine. It is the duty of government, whether it be city, state or nation. Therefore, if there has been any neglect of public health in any locality, the blame should be placed where it belongs—on government.

Adequate mdeical care in all its ramifications, (which would include clinics, dispensaries, hospitals, and the necessary laboratory tests and home visits) should be divided into three groups: (1) Those who cannot pay because of a disproportion between income and their medical needs; (2) those who should pay but find themselves in great difficulty because of their own budget limitations and ineptness in planning for illness; and (3) the smaller group who can pay for anything at any time.

Experience with the first group is available in San Francisco. With the second group, there is no doubt that medical opinion has been divided, but that division is more apparent than real. The division is in two schools: (1) compulsory health insurance, which many feel very definitely that these United States should never adopt; (2) voluntary health insurance which a large portion of the medical profession thinks should be the American system, and whereby the patient may have at a reasonable cost, choice of hospital and choice of physician.

The dentist and the nurse, especially in home care visits, are seldom, if ever at all, mentioned in such scheme, and yet the nurse is indispensable for the care of the ill, as is likewise the dentist in a great variety of diseases. Moreover, the seeming neglect of postgraduate training for the physician is an oft-repeated challenge not yet entirely answered by organized medicine or the medical colleges.

In San Francisco the limitations of government in medicine are thought consistent and there is no medical or public health neglect within the budget allowed. The

institutions of the Department of Public Health include the San Francisco Hospital, the Laguna Honda Home, the Hassler Health Home and the Emergency Hospital and ambulance service. More closely allied to the institutional section administratively, but also very closely related to the medical-dental-nursing section, are the chest diagnostic centers, the outpatient obstetrical service, the venereal disease diagnostic and treatment centers and the city physicians, treating persons in their homes.

If the program of public health should include hospitalization and home care of the indigent (classified as such because of their medical needs and limited earning capacity), which has not been the case heretofore in many localities, then again the matter is for government through health departments and not through organized medicine. There still would remain the care of the moderate income group. It is this group that becomes the piece de resistance for argumentative health insurance advocates.

It may be of interest to note that there has been a truly spectacular achievement of nonprofit health plans during the past eleven years. Despite the development which has taken place there are many who believe, and many who contend, that these plans have reached their full development and cannot be expected to reach a large proportion of the people. It has been predicted, however, that with the support of the medical and allied professions, and with the support of hospital trustees and executives, the people of this country can be relieved of the financial burden of curative health care within a reasonably few years through medical plans and the companion hospital plans.

It can be safely said today that the medical profession of California has actively participated in the development of prepayment medical and hospital care and has made a sound investment in its California Physicians' Service, the potential of which, from both the social and economic points of view, represents unknown resources which only time can reveal. The California Physician's Service should receive the support of Labor organizations and Federal Housing Agencies involved in housing workers in areas of concentration of population due to war industries.

The second matter of public health interest has been the various dairy bills, especially S.B. 153. The most important aspect of this bill is its bearing on the public health and the welfare of labor in this city.

The bill is designed to place all country dairy and milk inspection under the State Department of Agriculture, and to deprive the Approved Milk Inspection Services of cities and counties of the right to require additional safeguards which our conditions demand, and which are not provided for in the State Agricultural Code.

That part of the bill between lines 5 and 16, inclusive, on page 5, which declares that "No provision of this division . . . is a limitation on the power of the municipality," etc., is nothing more or less than camouflage, for it does take away authority which we now have, and does not actually grant anything in return.

While the bill would prohibit cities and counties from inspecting producing dairies and milk shipped therefrom into the cities, the cities would be compelled to sample producers milk and maintain a laboratory for bacteriological and chemical examination of such samples without being permitted to recover the cost thereof, a cost which should be assumed by the State, should this bill become law.

The tuberculin testing of dairy cattle would be adversely affected and the physical examination of herds would be made infrequently and by unqualified personnel.

Requirements for farm structures would be weakened, and chemical sterilization would be permitted. Raw milk would be permitted and milk pasteurized outside the city could be sold within the city. Pasteurization is the most important safeguard, yet by the terms of this bill we would have no control over milk pasteurized outside the city and sold within it.

Briefly, this bill should be opposed and defeated on the grounds that its enactment would jeopardize the public health of this city and deprive personnel of this city government and other workers, of their livelihood, by reducing the number of employments in the dairy industry in this city.

The responsibility for the protection of the milk supply should be placed in one agency. This bill definitely divides the responsibility, practically lowers all the standards set by our local ordinances, especially pasteurization and sterilization of equipment. No health officer could possibly subscribe to this bill in any form or manner.

Respectfully submitted,
J. C. Geiger, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Morton R. Gibbons, Sr., Chairman, 1947
Robert A. Peers, 1945 Hyman Miller, 1946
George H. Kress, ex officio

To the President and the House of Delegates:

The following is a brief "Report of the Committee on History and Obituaries."

War activities and physician shortage have diverted attention almost entirely from gathering of data concerning local current medical history, to National medical history in the making on a vast and rapidly expanding scale.

The Committee is accumulating all information which comes its way. It is hoped that details will be preserved by County Societies, as has been requested of them, so that compilation of California medical history may be resumed when there is again time, after V Day.

During the coming year, if sufficient clerical help is made available, the Committee hopes to carry out its plan of securing desirable information from all C.M.A. members who are or who have been in the Armed Forces. Lack of clerical assistance has made this impossible to date.

Respectfully submitted,
Morton R. Gibbons, Sr., *Chairman.*

In Memoriam

Alameda County
Vernon George Alderson (April 24, 1944)
Daniel Crosby (July 15, 1944)
Ruby L. Cunningham (June 25, 1944)
Carl Eduard Curdts (February 27, 1944)
Henry Louis Dietz (December 12, 1944)
Pauline Glaser Drennan (April 14, 1944)
Arthur Montell Smith (July 22, 1944)
Edward Kirby Ward (April 26, 1944)
Ossie Frank Wilmeth (August 25, 1944)

Butte County
Leslie Freudenthal (March 1, 1944)

Contra Costa County
Charles Robert Blake (December 27, 1944)

Fresno County
Harold Carold Soucey (December 25, 1944)

Kern County
George Edward Bahrenburg (December 20, 1944)
Henry George Crease (August 15, 1944)

Lassen County
George Scott Martin (October 8, 1944)

Los Angeles County
Kurt Friedrich Behne (January 15, 1944)
Oliver Preston Bourbon (April 25, 1944)
Robert Law Cunningham (September 10, 1944)

Edward Draper Curtin (In military service)
George Willoughby Dye (April 1, 1944)
Carl Fisher (June 7, 1944)
Atticus Greene Haygood (June 27, 1944)
Charles Henry Hayton (October 9, 1944)
Greg Hoskins (May 10, 1944)
Paul Mallers Hunter (April 28, 1944)
Milbank Johnson (October 3, 1944)
Roy Howard Johnson (July 24, 1944)
Ethel Leonard (April 12, 1944)
Elmer William Litle (September 8, 1944)
John Galbraith Mackey (February 12, 1944)
Edward Clarence Moore (July 10, 1944)
Arcadio Tigrio Obando (November 5, 1944)
Edward M. Pallette (November 16, 1944)
Jeddiah William Pidcock (October, 1944)
Frances M. Preston-Brown (August 18, 1944)
Albert Clifton Sellery (November 24, 1944)
Mark Harrison Smith (September 8, 1944)
Arthur Gilman Tullar (October 11, 1944)
Jesse Harold Turner (November 20, 1944)
Edward Huntington Williams (June 24, 1944)
Norman Harris Williams (December 18, 1944)

Merced County

Walter E. Lilley (March 31, 1944)

Monterey County

Maritn McAulay (November 3, 1944)

Nevada County

Dwight David Johnson (October 30, 1944)
Carl Power Jones (October 18, 1944)

Plumas County

John Wesley Moore (March 10, 1944)

Riverside County

James Albert Connell (September 24, 1944)
William Wallace Roblee (January 25, 1944)
Ralph Merle Smith (November 28, 1944)

Sacramento County

Wallace Rideout Briggs (December 18, 1944)
Eugene H. Pitts (May 1, 1944)
Charles Edward Schoff (May 28, 1944)

San Bernardino County

Robert Morris Dunsmoor (November 7, 1944)
Scott Ryerson (September 17, 1944)

San Diego County

Frank Albert Burton (April 25, 1944)
Maynard Caldwell Harding (February 12, 1944)
Harris James Stewart (October 31, 1944)

San Francisco County

Milton R. Alanson (August 16, 1944)
George Henry Boskowitz (February 24, 1944)
Walter Bernard Coffey (March 25, 1944)
Jerome Konigsberg (February 4, 1944)
Thomas Joseph Lennon (November 13, 1944)
William Murray Malone (February 17, 1944)
Leo Louis Meininger (October 9, 1944)
George Bernhard Miller (July 14, 1944)
Oscar Frederick Nolan (November 12, 1944)
Fermin Ralph Orella (December 4, 1944)
Albert Victor Pettit (November 19, 1944)
Charles Bradley Pinkham (July 14, 1944)
George Kremer Rhodes (July 23, 1944)
Howard Somers (January 21, 1944)
Isaac Walton Thorne (December 23, 1944)

San Joaquin County

George Proctor Cooper (July 18, 1944)
Treva Really Trick (July 20, 1944)

San Luis Obispo County

Henry Fenno Sawtelle (December 2, 1944)

Santa Barbara County

Henry James Profant (April 29, 1944)

Santa Clara County

Howard Black (September 21, 1944)
Leonard Wheeler Ely (June 17, 1944)

Santa Cruz County

Angelo David Garibotti (December 14, 1944)
Frederick Herman Koepke (May 18, 1944)

Tulare County

Reuben Chandler Hill (November 20, 1944)

Yuba County

Everett Edwin Gray (February 6, 1944)
George West Stratton (August 29, 1944)

Ventura County

William Rodman Manning (January 10, 1944)

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Executive Group

Roy E. Thomas, Chairman, 1947
J. Norman O'Neill, 1945 Benjamin B. Black, 1946

To the President and the House of Delegates:

Under these wartime conditions the public and even the private hospitals have been greatly handicapped through lack of adequate personnel in both the attending and the house staffs. In these institutions every effort is being made to carry on work to as good advantage as possible under existing conditions.

It has been encouraging to note in the newspapers that the State Board of Public Health proposes to bring into being laws that will make for an improvement in registration and standardization of hospital work.

Efforts to promote such objectives are worthy of support.

Respectfully submitted,
Roy E. Thomas, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Donald Cass, Chairman, 1945
Carl L. Hoag, 1946 N. P. Dunne, 1947

To the President and the House of Delegates:

Your Committee on Industrial Practice has had no meetings during the past year. The development of Industrial Fee Schedules and Proposed Legislation which the California Medical Association has forwarded to the Legislature has to do with the increase in fee schedule for industrial practice and also for regulatory powers of Industrial Accident Commission in the establishment of future fee schedules. This work is practically all being done now by a special committee headed by our legal staff, Mr. Hartley Peart.

It will be interesting and important as time passes, especially after the present Legislature meets, for this committee to carry on the supervision of Industrial Practice in conjunction not only with the State Medical Association but also with the association of Industrial Surgeons.

Respectfully submitted,
Donald Cass, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

Glenn F. Cushman, Chairman, 1947
C. A. Broaddus, 1945 Edward C. Pallette, 1946

To the President and the House of Delegates:

Because two of the members of this committee are in service, very little active work has been done.

The economic phases of proposed sickness insurance laws now pending in the California Legislature is given consideration elsewhere. Also the efforts to secure a readjustment in fee tables of California Industrial Accident Commission.

Respectfully submitted,
C. A. Broaddus, *for the Committee.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

B. O. Raulston, Chairman, 1947
L. R. Chandler, 1945 William J. Kerr, 1946

To the President and the House of Delegates:

It appears that with the end of the present calendar year the Army and Navy will no longer assign groups of students to medical schools as they have done during the last few years. Unless some arrangement is made whereby premedical students may be deferred from military service, the schools must depend upon men who are physically unqualified for such service, and women. If

such is to be the arrangement there will of necessity be a considerable change in the student body, in comparison to previous times. It is hoped that there may be changes in the military program that will influence favorably the supply of students for the freshman classes of the medical schools for 1946. The number of veterans who will be ready for medical school is not expected to alter this situation materially during the next year.

Accelerated programs of training are to be continued for all students who are in the Army or Navy units of the medical schools, although the schools may admit but one class per calendar year if they choose.

Provision for an adequate number of residencies and of post graduate courses for those who are to return from military duty constitutes a serious problem. Each of the four schools in California has a committee working on plans for such training.

The possible influence of compulsory health insurance upon medical education has had careful consideration. Discussion of this subject would be too lengthy for this report. It may be said that at least the most discussed bills dealing with this subject have given careful consideration to possible effects upon medical education and that their sponsors have indicated an earnest desire to avoid any interference with the existing teaching programs.

The possibility of Federal Government support of research work in medical schools during the post-war period is interesting, and probably vitally important.

Respectfully submitted,

B. O. Raulston, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

Nelson J. Howard, Chairman, 1947
C. Kelly Canelo, 1945 Louis J. Regan, 1946

To the President and the House of Delegates:

Executive Secretary John Hutton has written to all State Medical Societies enclosing a questionnaire on malpractice insurance compiled by Mr. Hunton, Mr. Hassard and the writer. The replies of the individual states are coming in and when carefully studied should furnish valuable material to aid in solving malpractice insurance problems for the doctors of our State.

Respectfully submitted,

Nelson J. Howard, *Chairman.*

COMMITTEE ON PUBLICATIONS

Executive Group

George W. Walker, Chairman, 1946
Francis E. Toomey, 1945
C. Burton Jones, 1947 George H. Kress, ex-officio

To the President and the House of Delegates:

It has been difficult in the past years, because of Government restrictions, to find space to publish all that should have been published. Extra demands brought on by essential wartime articles have crowded other meritorious material, but every effort possible has been made to publish all for which room could be found.

Respectfully submitted,

George W. Walker, *Chairman.*

COMMITTEE ON POST GRADUATE ACTIVITIES

Executive Group

F. E. Clough, Chairman, 1946
Frank A. MacDonald, 1945 H. F. Freidell, 1947
George H. Kress, Secretary, ex-officio

To the President and the House of Delegates:

The work of the Postgraduate Committee has been at very low ebb during the past year. So many more important matters have presented themselves that scientific medical meetings throughout the State have been superceded, to a large extent, by meetings limited to the discussion of economic problems.

Then, too, so much work has been piled on the doctors remaining in private practice that they are too exhausted to attend medical meetings where further mental effort is necessary.

Through the secretary's office of the Association Secretary, who functions as secretary of the Postgraduate Committee the usual supply of medical reprints, journals and other materials has been sent to the various army and navy hospitals throughout the State.

During the coming year, it is hoped to make available for use, medical and surgical films.

The committee begs the indulgence of the association for such limited work.

Respectfully submitted,

F. E. Clough, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

Executive Group

Donald Cass, Chairman

To the President and the House of Delegates:

The Committee on Public Relations has not been active as such during the past year. The Committee contains on its roster of members many who are members of the Council and other committees. The Committee on Public Relations has had no occasion for meetings in as much as our Public Relations activity has more or less entirely been taken from the hands of regular committees and assigned to professional full-time employees as well as to special committees who are closely in coöperation with our Public Relations Staff.

Public Relations in the future will become more and more important and unquestionably the Committee will assume greater responsibilities as it is possible to relegate some of these activities to the Committee Members, but at present with the press of imminent compulsory health service in the offing, we will probably find that Public Health Relations will be committed entirely to our professional employees.

Respectfully submitted,

Donald Cass, *Chairman.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

George H. Kress, Chairman, ex-officio
Howard F. West, 1945 Fletcher B. Taylor, 1946
J. Homer Woolsey, 1947
Salvatore P. Lucia, ex-officio (for Medicine)
Leon Goldman, Ex-officio (for Surgery)

To the President and the House of Delegates:

When World War II began, it became necessary to change the four-day session of the annual conference of the California Medical Association to two-day, streamlined meetings. Several years ago Hotel Del Monte, in Del Monte, at the suggestion of the C.M.A. Committee on Scientific Work, erected a pavilion with some eight assembly rooms, and it was hoped that thus an arrangement had been created through which members of the California Medical Association from all parts of the State would be able to attend Annual Session meetings with a minimum of inconvenience, and in an environment where the facilities would make for a maximum of scientific and other benefits.

However, the Navy moved in and took over the Hotel Del Monte and its assembly pavilion. Nevertheless, if the Hotel should ever become operative again, the additional meeting rooms erected by the Navy will make Del Monte more attractive than ever to the California Medical Association as a meeting place.

Since Hotel Del Monte was no longer available, it became necessary to secure accommodations at the only

other hotel in California able to provide an adequate number of meeting rooms with facilities for non-resident members. Such a place was found in the Hotel Biltmore in Los Angeles, where a battery of twelve assembly rooms could be used.

However, some months ago new complications arose, due to the announcement by the Federal Office of Defense Transportation that all conventions that would require transportation from any distance of more than 50 persons, with resultant wartime interference in hotel accommodations and use of manpower in hotels, should be given up for the Duration. This ruling necessitated a complete revision of C.M.A. annual session plans.

Accordingly, transportation for the members of the business division of the organization, the C.M.A. House of Delegates, was limited to less than fifty persons.

The scientific meetings were placed under the auspices of the Los Angeles County Medical Association, because the attendance at those meetings will be practically limited to members of that and other near-by county medical societies, who can use their own auto or local service. The attendance should be good because the Los Angeles County Medical Association has in excess of 3,000 members, being exceeded in number by only ten state associations (New York, 18,908; Pennsylvania, 9,951; Illinois, 8,623; [California, 7,550]; Ohio, 6,752; Massachusetts, 5,528; Texas, 4,607; Michigan, 4,567; New Jersey, 4,294; Indiana, 3,397; Missouri, 3,252.)

The Committee on Scientific Work proposed that annual session papers submitted by C.M.A. members who are non-residents of Los Angeles be read by title; that is, the papers placed on the program and so become eligible for publication in California and Western Medicine, even though the authors were not in attendance, and the Council approved this plan.

The Central C.M.A. Committee on Scientific Work extends thanks to the Officers of the thirteen Scientific Sections who have rendered excellent coöperation in securing papers under the adverse conditions now prevailing.

Special thanks are due the Wartime Graduate Medical Meetings Committee, which has been working in conjunction with the American Medical Association, the American College of Physicians, and the American College of Surgeons. The Committee for the 24th Zone (Southern California) consists of: Lt. Comdr. George C. Griffith, (MC), USNR, Corona, chairman; Capt. Harry P. Schenck, (MC), USNR, Oceanside; Wayland A. Morrison, M.D., Los Angeles; and James F. Churchill, M.D., San Diego.

The undersigned chairman of the Committee on Scientific Work is under special obligation to Lt. Comdr. George C. Griffith of Corona for the generous help rendered by the Wartime Graduate Medical Meetings Committee, because through Dr. Griffith, it has been possible to secure from nearby Army, Navy and Air Force camps some fourteen essayists, most of whom in civilian life occupied important teaching and hospital positions in other States of the Union.

This year, the complete program of Scientific Sections with abstracts of papers will not be printed in California and Western Medicine. However, a list of the papers will appear in the *Bulletin of the Los Angeles County Medical Association*, and at the meetings, the usual program containing abstracts will be distributed to all who are in attendance.

These explanatory comments have been made for the information of members who may not be aware of the conditions under which it has been necessary to proceed with the work this year.

Thanks are extended to all who have rendered coöperation.

Respectfully submitted,
George H. Kress, *Chairman.*

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Executive Group

J. F. Doughty, Chairman, 1945
L. H. Rederlings, 1946 Carl F. Mulfinger, 1947

To the President and the House of Delegates:

In accordance with the Constitution and By-Laws there is appended herewith, a summary of the C.M.A. County Society membership totals for the year 1944, as compiled by our central office.

In an effort to be helpful to the men who are returning from the military services, a letter has been written to each component society urging that special attention be devoted to securing the membership of these individuals promptly. We desire the advice and leadership of these men in the problems facing the medical profession. We wish to give them every assistance possible in the resumption of civilian practice.

Respectfully submitted,
J. F. Doughty, *Chairman.*

C.M.A. County Society Membership Totals for Year 1944

County Medical Societies	*Membership in 1943*	*Number Licensed Physicians (1944 State Directory)* (C.M.A. and non-C.M.A.)*	*Civilian C.M.A. Members in 1944*	*Military C.M.A. Members 1944*	*Total C.M.A. Members 1944*
Alameda	612	754	449	187	636
Butte-Glenn	38	39	26	10	36
Contra Costa	57	97	61	7	68
Fresno	151	141	115	41	156
Humboldt	36	37	24	12	36
Imperial	28	23	15	10	25
Inyo-Mono	11	11	8	4	12
Kern	76	97	58	20	78
Kings	23	20	14	9	23
Lassen-Plumas-Modoc	22	22	15	5	20
Los Angeles	2,922	4,031	2,289	806	3,095
Marin	50	56	34	18	52
Mendocino-Lake	29	36	18	10	28
Merced	34	23	14	16	30
Monterey	70	72	50	25	75
Napa	39	46	32	9	41
Orange	127	138	96	39	135
Placer-Nevada-Sierra	39	38	28	10	38
Riverside	74	108	60	19	79
Sacramento	174	167	127	51	178
San Benito	9	10	5	2	7
San Bernardino	166	180	135	48	183
San Diego	349	436	256	111	367
San Francisco	1,168	1,491	804	393	1,197
San Joaquin	107	88	72	38	110
San Luis Obispo	32	31	25	5	30
San Mateo	94	109	76	22	98
Santa Barbara	127	108	85	43	128
Santa Clara	234	225	155	78	233
Santa Cruz	46	43	30	15	45
Shasta	26	20	18	8	26
Siskiyou	15	18	12	2	14
Solano	47	68	44	5	49
Sonoma	72	72	53	20	73
Stanislaus	52	53	39	17	56
Tehama	7	15	7	1	8
Tulare	53	56	40	16	56
Ventura	53	52	32	20	52
Yolo	29	17	15	12	27
Yuba-Sutter-Colusa	29	24	16	11	27
Total	7,327	9,072	5,452	2,175	7,627

* Note. The numbers of licensed physicians under the respective counties are those which appear in such listings in the 1944 Directory of the State Board of Medical Examiners. The State Board of Medical Examiners does not list in the county rosters the names of licensed physicians who are in military service. These are listed in the alphabetical index which commences on page 53 of the 1944 Directory, the name of each such military member being marked by a star.

EDITORIAL BOARD

Chairman of the Board:
Albert J. Scholl, Los Angeles

Executive Committee:
Lambert B. Coblentz, San Francisco
Fred D. Heegler, Napa
Albert J. Scholl, Los Angeles
George W. Walker, Fresno

Anesthesiology:
H. R. Hathaway, San Francisco
Lawrence D. Lee, Los Angeles

Dermatology and Syphilology:
William H. Goeckerman, Los Angeles
H. J. Templeton, Oakland

Eye, Ear, Nose nad Throat:
Frederick C. Cordes, San Francisco
L. G. Hunnicutt, Pasadena
George W. Walker, Fresno

General Medicine:
Lambert B. Coblentz, San Francisco
L. Dale Huffman, Hollywood
Mast Wolfson, Monterey

General Surgery (including Orthopedics):
Frederic C. Bost, San Francisco
Fred D. Heegler, Napa
William P. Kroger, Los Angeles

Industrial Medicine and Surgery:
John D. Gillis, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
William S. Kiskadden, Los Angeles
George W. Pierce, San Francisco

Neuropsychiatry:
Olga Bridgman, San Francisco
John B. Doyle, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles

Pediatrics:
William W. Belford, San Diego
William C. Deamer, San Francisco

Pathology and Bacteriology:
Alvin J. Cox, Jr., San Francisco
R. J. Pickard, San Diego

Radiology:
R. R. Newell, San Francisco
Henry J. Ullmann, Santa Barbara

Urology:
Lewis Michelson, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

To the President and the House of Delegates:

Thanks are hereby given to members of the Board for their valuable assistance and ideas.

The demand for space has increased considerably even over previous years, and the reduction in size of the California and Western Medicine obtains as of last year.

Impending federal legislation on such subjects as the Wagner-Murray-Dingell Bill together with the need for space to cover special council meetings take up many pages. In recent months the various reports on Association activities have required from ten to fifteen pages per issue.

The Executive Committee of the Editorial Board recommended to the Council, the great need of additional help in the Editor's office. Under existing conditions it is not possible to properly maintain the files and keep up with proper editorial work.

In spite of these greater demands for space, our editor has been able to find room for many worth-while scientific and general papers.

Respectfully submitted,
Albert J. Scholl, *Chairman.*

COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

* * *

PROCUREMENT AND ASSIGNMENT SERVICE

Executive Group
Harold A. Fletcher, San Francisco
Chairman for Northern California
William H. Kiger, Los Angeles
Chairman for Southern California

To the President and the House of Delegates:

During the past year the program for the Procurement and Assignment Service for Physicians in northern California has been a very busy one. A continual checking and re-checking of surveys as to the ratio—of doctors to population has been kept up. There have been many changes in population as well as in the supply of doctors in various localities. One of the chief parts of the program has been that of relocation of physicians where needed. A large number of physicians have been relocated in various needed areas. These physicians have been from out of the State or from one area in the State to another, and in addition, physicians who have been discharged from the military forces.

Very few physicians have been made available for the military forces during the past year. With the exception of a few large centers, the bottom of the barrel has been reached, and only an occasional physician can be made available, and such physicians only when they can be replaced by someone else. The army discontinued accepting physicians from civilian life during the middle of 1944. This was in order to give the navy a chance to recruit more medical men. However, California has very few men who can be released to the military forces.

A recent check-up in this office shows that 70 male physicians and 53 female physicians in Northern California under 38 years of age have never been made available and have therefore never applied for military commissions. These 70 physicians have essential positions and could not be released.

The Central Board of Procurement and Assignment Service realizing the above facts, has made no additional quota as far as California is concerned. Certain states have never met their quota and they still have a great many available physicians, particularly in the crowded eastern cities, Recruitment in those places has been particularly slow, and California can well feel proud of its contribution to the military forces of physicians.

The Coördinating Committee on medical care of the Procurement and Assignment Service has been busy during the last year with many medical problems. The problems taken by this Committee have been the endeavor to solve the needs of medical care in various expansion areas. It has given a good deal of time and study to the problems of the Nurses' Procurement and Assignment Service, endeavoring to help the nurses in their very critical task of providing the needed nursing care for the military forces, as well as maintaining a reasonable distribution on the home front.

The remaining problem for the Procurement and Assignment Service is mostly one of relocation of physicians. It is my opinion that this problem should be turned back to the State Society in the near future. The problems entail hundreds, if not thousands, of physicians who are contemplating locating in California, either before the end of the emergency or immediately thereafter. This will confront California with a good many problems, and I feel that the medical profession, as represented by the California Medical Association, will take this problem very seriously, with the definite idea of guiding the problems in the future. The various component county medical societies have been very helpful in backing up the Procurement and Assignment Service in the problems of relocation of physicians where they are needed.

Respectfully submitted,
Harold A. Fletcher, *Chairman.*

COMMITTEE ON LOCAL ARRANGEMENTS

Executive Group

E. T. Remmen, Chairman

Louis G. Regan — George H. Kress, ex-officio
Ralph B. Eusden — S. K. Cochems

To the President and the House of Delegates:

The report of the Committee on Scientific Work will explain the difficulties met with this year because of the rules of the Federal Office of Defense Transportation.

As stated in CALIFORNIA AND WESTERN MEDICINE, the scientific meetings will be held this year largely under the auspices of the Los Angeles County Medical Association, in order to comply with the Washington, D. C., directive to avoid all unnecessary railroad transportation.

The Committee on Scientific Work has arranged to use the facilities of the Elks Temple and the Los Angeles County Medical Association headquarters. Publicity concerning the programs will be given in the *"Bulletin of the Los Angeles County Medical Association."*

Respectfully submitted.

E. T. Remmen, *Chairman.*

COMMITTEE ON PHYSICIANS' BENEVOLENCE

Executive Group

Axcel E. Anderson, Chairman

Robert A. Peers — Elizabeth Mason-Hohl

To the President and the House of Delegates:

For the calendar year 1944 the Physicians' Benevolence Committee had receipts of $6,589.58 and made disbursements of $3,600, leaving the accumulated funds of the committee at $13,945.28 at the year-end.

Receipts from the California Medical Association at the rate of $1 per active member amounted to $5,498; the Woman's Auxiliary contributed $1,041.58, and interest on savings accounts totaled $50.

Disbursements were made to the Los Angeles County Physicians' Aid Association, which has had the burden of caring for our needy colleagues with funds collected from individual subscriptions. This association last year looked after the needs of thirty-one persons, including physicians and their dependents. These people were cared for in nursing homes and hospitals, were supplied with items beyond their own budget possibilities and were eased over many rough spots which could not be smoothed out by other means at their disposal.

After this care had been given, the Physicians' Benevolence Fund showed $7,293.50 on hand in its current account at the close of 1944 and another $6,651.78 in savings accounts which are intended to serve as a nucleus for a permanent endowment fund. The contribution of the C.M.A. and the Woman's Auxiliary has made it possible to meet our daily needs and to set aside funds for the endowment drive. Our appreciation is gratefully expressed to both these organizations for their willing help in this worthy cause.

Respectfully submitted,

Axcel E. Anderson, *Chairman.*

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates		*Alternates*
Dwight L. Wilbur	(1944-1945)	Anthony B. Diepenbrock
S. J. McClendon	(1944-1945)	Bon O. Adams
Lowell S. Goin	(1944-1945)	Leo J. Madsen
Dwight H. Murray	(1944-1945)	John W. Green
H. Gordon MacLean	(1945-1946)	Leopold H. Fraser
E. Vincent Askey	(1945-1946)	Donald G. Tollefson
John W. Cline	(1945-1946)	C. Kelly Canelo
Donald Cass	(1945-1946)	Ralph B. Eusden

To the President and the House of Delegates:

The California delegation to the A.M.A. reported its activities to the Council in August, 1944, and this report has already been published. A summary report is therefore in order at this time.

Doctor Murray was elected chairman of the delegation, which was a complete roster of the elected delegates. Doctor Wilbur was selected to present the California resolutions, seven in number.

On action by the A.M.A. House of Delegates, the California resolutions were decided as follows: three were passed, either as written or in principle, and four were rejected. Approved were resolutions calling for the creation of a Federal Department of Health, to be headed by a cabinet officer, and two resolutions proposing a more acceptable E.M.I.C. program under the Children's Bureau. Rejected were resolutions asking for a nationwide survey of public opinion, a resolution asking A.M.A. approval of the United Public Health League, and the two California resolutions suggesting changes in the official A.M.A. staff.

The delegation left the 1944 A.M.A. meeting with the feeling that it had truthfully represented the wishes of the C.M.A. House of Delegates and had done its best to accomplish its instructed purposes. It is felt that many friends have been made and that California programs in later years will find more adequate support in the A.M.A. House of Delegates.

The Delegates have suggested that future California delegations to the A.M.A. should hold preliminary caucuses before leaving California and prior to the opening of the A.M.A. sessions. In this way it is believed that much greater accomplishments can be gained.

Respectfully submitted,

Dwight H. Murray, *Chairman.*

CANCER COMMISSION

Executive Group

Harold Brunn, Chairman, 1946
Lyell C. Kinney, Vice-Chairman, 1946
Otto H. Pflueger, Secretary, 1946

Alson R. Kilgore, 1945 — George Sharp, 1947
Henry J. Ullmann, 1945 — Whitfield Crane, 1947
Gertrude Moore, 1947
Clarence J. Berne, Secretary for Southern Section, 1945

To the President and the House of Delegates:

As Chairman of the Cancer Commission of the California Medical Association, I wish to submit the following report.

As before your Committee has coöperated with the Women's Field Army of the American Society for the Control of Cancer now called the American Cancer Society, headed by Dr. C. C. Little of Bar Harbor, Maine. The American Cancer Society has enlarged its operations and during the coming year will probably be the authority on cancer conditions throughout the United States. The Field Army has been most coöperative. They have sent out a considerable amount of literature to lay people and are planning radio talks and spot announcements on the radio. A list of members of the San Francisco County Medical Society is being prepared so that we may have available speakers to appear before lay organizations such as Women's Clubs upon request.

The month of April has been designated by the President of the American Cancer Society as the month which throughout the U. S. collections will be made for general and local use. On April 16th a dinner is projected at the Palace Hotel where prominent speakers from the East will explain the need of the work done by the Cancer Committee. We have hopes that Dr. Little will be present. We are also projecting one night at the County Medical Society for a cancer program.

There has been during this season a good deal of discussion in regard to the formation of a Detection Clinic in San Francisco. Your Committee discussed the subject and representation was also made to the San Francisco County Medical Society directors for recognition of this

work. It was the opinion of your Committee that San Francisco was peculiarly placed at the present time on account of the war effort. Not only is there an increase in our population but there is a depletion of our doctors. They felt that this was no time to start this new program but that it should be delayed until some of the men returned from the war. Also it would be necessary to have funds to carry out this plan which will require considerable expense. There was no desire to delay the program any further than necessary. Other cities have already put in motion such a plan but it was thought best owing to these circumstances that this project should be delayed at the present time.

It is recognized by the Committee that the little brochure on Cancer which was formulated through the work of Dr. Alson Kilgore and Dr. Otto Pflueger should be revised as considerable progress has been made in the treatment of cancer since the time of its distribution. Here again it was thought best to delay action until a later date for the reason given above.

Your Committee is still working on the problem of making cancer a reportable disease and also interesting the State of California in an enlarged cancer program and a report of these efforts will be made at a later date.

Respectfully submitted,

Harold Brunn, *Chairman.*

CALIFORNIA PHYSICIANS' SERVICE

Summary of Actions of the Board of Trustees of California Physicians' Service

May, 1944 to March, 1945

The new Board of Trustees of C.P.S. had its first meeting on May 8th, 1944. New members of the board are:

Chester L. Cooley, M.D., San Francisco
C. Glenn Curtis, M.D., Brea
P. K. Gilman, M.D., San Francisco
H. Randall Madeley, M.D., Vallejo
A. E. Moore, M.D., San Diego
C. L. Mulfinger, M.D., Los Angeles
Fletcher B. Taylor, M.D., Alameda

Continuing members are:

Dr. Ray Lyman Wilbur, Stanford University
T. Henshaw Kelly, M.D., San Francisco
Glenn Myers, M.D., Los Angeles
Rt. Rev. Msgr. Thomas J. O'Dwyer, Los Angeles (re-elected)

At the organization meeting, the following officers were elected:

Ray Lyman Wilbur, President
Glenn Myers, First Vice-President
Fletcher B. Taylor, Second Vice-President
T. Henshaw Kelly, Secretary
Chester L. Cooley, Treasurer
C. L. Mulfinger, Assistant Secretary-Treasurer

I. REORGANIZATION

On June 11th, at the first regular meeting, Doctors Cline and Schaupp, representing the Executive Committee of the California Medical Association, spoke to the board in relation to the Foote, Cone and Belding report, and urged the employment of a highly competent overall executive. A committee of three was appointed to seek the proper man.

The committee has found that skilled executives are extremely scarce, and those that can be found are currently employed at very high salaries. Competent men are reluctant to leave well-paid positions to embark on a new venture, strange to them and full of internal conflicts and confusions, and, unhappily, differences of purpose. Lately the political situation, both nationally and in California, has increased the board's difficulty in locating anyone who would be interested.

Thus through necessity there has been reorganization of the existing administrative personnel of C.P.S., in a determined effort to use to the best possible advantage the trained people who have worked hard for C.P.S. since its beginnings. Without doubt, due to the necessity that C.P.S. operate and try to grow on a financial shoestring, the administrative personnel had not been efficiently organized, and several men had been forced—because there was no one else to do it—to undertake tasks for which they were not ideally suited.

A first step, and a major one, was to reorganize the Los Angeles office, which had not been functioning efficiently or to the satisfaction of the profession in the Southern area. Mr. Ebersole's transfer to the C.M.A. Department of Public Relations left a void. The loss of Dr. Hope, Assistant Medical Director, who entered the army about two years ago, had been seriously felt at all times. To correct this situation, the board directed Mr. William M. Bowman to take full charge of the Los Angeles office. He became Assistant Director, and has been in complete charge of the Southern territory since July, 1944. In the fall, Dr. W. H. Gardenier became the head of the Medical Department in the Southern area. Mr. Bowman has reorganized the Los Angeles office, and under the direction of the Executive Director (Dr. Larsen) has remedied many of the previous flaws.

At San Francisco, the administrative functions have been departmentalized. Dr. Larsen is Medical Director and Executive Director. Mr. Kelly, as Assistant Director, is in charge of office management procedures and accounting functions. He serves, in effect, as controller. Mr. Lyon is in charge of the War Housing Projects.

These and other definite administrative changes have markedly increased the efficiency of the organization.

II. NEW PAYMENT SYSTEM

At the June meeting the board approved a change in the method of operations of C.P.S. with relation to its payment to the profession. This was predicated on the belief that sufficient reserves had been accumulated so that a unit value could be safely predicted in advance of the actual information regarding income and expenditures. This, in effect, speeded up the payment to doctors by a matter of at least six weeks. The previous system required C.P.S. to wait until all bills had been received, and then the unit value was calculated on the basis of the net for that particular month.

III. ADMINISTRATIVE MEMBERSHIP

Consideration has been given to the report of Dr. Bruck, as Chairman of the Resolutions and Nominating Committee, that his committee had received suggestions from various members for lay Administrative Members. The board will have several names to present at the May meeting. Administrative Members are urged to come with other possible names.

IV. FEE SCHEDULE

The board was acquainted with the problems relative to the basic fee schedule of C.P.S. It was pointed out that the fee schedule in effect is one of the basic factors controlling the cost of service, and directly transfers this cost to the purchasing public. This fee schedule was originally developed by the organizers of C.P.S. and had been submitted to the various Specialty Sections of the C.M.A. for revision in 1940. Subsequent hearings were held with subcommittees of these sections in 1942. Since then, specific items have been altered by action of the Board of Trustees. It is well to note that in all of its major items this schedule, due to local conditions, averages 25 to 30 per cent higher than those of any other Statewide plan in the East and Midwest, so that when the unit of C.P.S. was $1.90, or 76 per cent of our par

value, C.P.S. could have been paying 100 per cent par value of the others.

It was the consensus that a thorough review of this fee schedule should be made again at this time, and that a permanent Fee Schedule Committee should be in operation, composed of members of the profession at large who had no formal connection with the activities of C.P.S. They were to be representative of metropolitan, urban and rural medicine, so that equitable adjustments in relation to these varying conditions could be made. It was felt that general practitioners and representative specialties should also be included. This committee is being appointed.

I. RELATIONS WITH HOSPITAL ASSOCIATIONS

Continuous coöperation with committees from C.M.A. and the Hospital Service Associations has been going on during the past year. Negotiations remain in a static position. Until there is one Statewide hospital plan, C.P.S. is not called upon to take any action.

VI. NEVADA

Consideration was given by the board to a request from the Chairman of the Nevada Medical Association's Committee on Medical Service and Public Relations, for assistance in developing a prepaid plan in the State of Nevada. The board has subsequently acted to assist Nevada in every way to accomplish this.

VII. NEW PROFESSIONAL MEMBERS

In the interest of securing an increasing number of professional members, C.P.S. has had the coöperation of the individual County Societies, through the Council of C.M.A., in providing information about C.P.S. to new members and resubmitting it to others who had not become members in the past, so that they might consider the advisability of becoming members. This activity has resulted in marked improvements in membership, especially in the County of San Diego, where more than 80 professional members have been acquired. In the State as a whole, since May of 1944, 450 doctors have either reaffirmed their coöperation to C.P.S. or have become new members. There are now 5,556 throughout the State.

VIII. BENEFICIARY MEMBERSHIP GROWTH

In May of 1944, membership in C.P.S. Commercial Program numbered 64,500. As of this writing (March, 1945), the membership is 123,000. C.P.S. almost doubled in size. This has been due to expanding acquisition activity, a better response by the public and employers; and equally, if not more important, the increasing solidarity of the medical profession as a whole in backing C.P.S., and the individual physician in rendering excellent service to beneficiary members. There are still many things, under these favorable conditions, that C.P.S. could do to increase its membership if it had resources independent of members' dues. It is the board's opinion that a comprehensive Statewide sales promotion program ought to be carried out as soon as possible. Such a campaign, however, is costly, and funds will have to be found elsewhere if it is to be done. Perhaps the C.M.A. could re-loan some of the funds returned to it.

It will be recalled that C.P.S. commenced operations in 1939 without any capital other than the $5.00 contributed by each professional member. To furnish a capital fund, the C.M.A. loaned C.P.S. an aggregate of $42,000. This money was used by C.P.S. during its organization period. Repayments on the loan were commenced in 1943, and in August, 1944, the loan was entirely repaid, so that at the present time C.P.S. is not financially indebted to the C.M.A.

IX. WASHINGTON, D. C., HEARINGS

Dr. T. Henshaw Kelly, as secretary of the board, represented C.P.S. before the Pepper Subcommittee on Wartime Health and Education, where C.P.S. made a very favorable impression. It is of interest that C.P.S. was the only medical service plan in the country called before this committee, and it was Senator Pepper's statement that C.P.S. would be subject to further investigation by the committee's field staff.

X. INCREASED DUES *(Reasons for Action of Board)*

The actuarial status of C.P.S. was reactivated from the studies that have been going on since the beginnings of C.P.S. These have been under the direction of Mr. Ralph R. Nelson, Consulting Actuary to C.P.S. Mr. Nelson is Consulting Actuary to the Retirement Board, and also was instrumental in accomplishing the solvency of the San Francisco Health Service. Being one of the few actuaries acquainted with medical service plans, and having one of the best ratings among actuaries, he has been called upon frequently to advise methods of keeping statistics for use at periods when they may become necessary. Formal reports had been submitted in December, 1943, and January, 1944. These indicated the need for a change in rates.

He advised the board that sufficient experience had been accumulated so that conclusive advice could be given at this time to readjustments in order to achieve a more equitable unit value. The board felt it was timely that action should be taken, and asked for final recommendations.

Mr. Nelson told the board that there is enough actual data from C.P.S.'s own experience to prove that the unit cannot be more than about $2.00 under the rates and benefits in effect at that time; that if the board wanted to increase the unit value to an amount comparable to fees charged moderate income patients in private practice, it was essential either to reduce benefits or increase rates. We quote from Mr. Nelson's report:

> "You have a choice of raising rates, reducing your benefits or lowering units—or any combination of these. To reduce your service . . . would be defeating the purpose you had in mind, to provide as nearly adequate medical service as you can give. In cutting out the first two visits, you did what was almost exactly necessary to handle medical service."

The board decided not to reduce benefits, but to increase rates, and it accepted Mr. Nelson's recommendations as to the amount of increase necessary in each instance. The new rates were approved, and are now in the process of being put into effect. The change should be completed by June of 1945 in the majority of groups. At our present annual income of $1,500,000, the increases will bring an additional $500,000 of income. With this it is estimated that there will be sufficient funds to wipe out any deficit that has accumulated due to delays beyond the control of C.P.S., and to provide for reserves which may eventually lead to increased benefits to the public.

Considerable apprehension toward this change was evinced by the Hospital Service of Southern California, with whom C.P.S. has joint acquisition activities. Preliminary contacts with groups concerning the rate change indicate that no great reaction on the part of the public will be encountered.

XI. INCOME CEILING

It has been felt that it was timely to again reconsider C.P.S.'s approach to the public with respect to the $3,000 income limitation. It was felt that possibly there could never be a solution to this problem satisfactory to both the profession and the public. In the past, C.P.S had attempted to meet it by issuing the surgical reimbursement contract to those with incomes above $3,000, but this method has not proven satisfactory. In some respects it worked better for the profession, but these were out-

weighed by the unsatisfactory relations with the public.

C.P.S. has returned to its original system, and it is much the same as that used successfully in Michigan. This method requires individual physicians to be conscious of the incomes of C.P.S. beneficiaries, to the end that those with incomes under $3,000 may not be charged additional amounts, but will receive service on the fee schedule of C.P.S. Those with incomes over $3,000 will be instructed by C.P.S. representatives that additional charges may be made by the physician. The profession and the public generally are being informed of this. In effect, this action eliminates further issuance of the surgical indemnity contracts.

XII. RURAL PROGRAM

The Rural Health Program has continued throughout the year, with some decrease in membership due to the increase in farmers' incomes, so that they are therefore no longer eligible to become borrowers through the Farm Security Administration.

XIII. WAR HOUSING PROGRAM

The War Housing Program is continuing in Wilmington, Channel Heights (in the Long Beach area), Marin City and Vallejo. Most of the early difficulties of this complicated program have been overcome. The program was undertaken as a war emergency, and has definitely fulfilled its purpose.

In March, 1944, the Executive Committee of the C.M.A., to meet the problem of the shortage of medical care, urgently requested C.P.S. to establish an emergency medical center at Richmond to meet emergency needs in the area. As C.P.S. had no funds to undertake a project of this kind, the C.M.A. underwrote the expenses of starting and maintaining the emergency center, which continues to function.

XIV. LEGAL STATUS

C.P.S. is pleased to report that on February 15, 1945, the District Court of Appeal decided the case of California Physicians' Service vs. the Insurance Commissioner. This was the action commenced in 1940 to determine whether C.P.S. was or was not legally operating as a service organization. The court held entirely in favor of C.P.S., and decided that C.P.S. is not in the insurance business, but that it is a service organization in the nature of a coöperative. The original action of the 1938 House of Delegates in rejecting insurance and deciding in favor of a service plan has been fully vindicated.

SUMMARY

During the past year, therefore, the Board of Trustees attempted and failed to find a satisfactory overall executive in these times when few are unemployed.

The acquisition arrangements with Hospital Service of Southern California were completely reorganized, an Assistant Director for the south being placed in Los Angeles as the C.P.S. member of that Acquisition Committee, with the power of decision, and a subsection of the Executive Committee was appointed in Los Angeles to work more quickly and effectively in matters affecting our southern operations. Increase in production has resulted.

Changes have been made in office procedures, resulting in reduced costs and more rapid payment to professional members, and the rates of C.P.S. have now been fixed by actuarial study at the levels necessary to produce a $2.50 unit, and these rates will be in effect in time to produce the needed increase in the income of C.P.S.

The relations between C.P.S. and its professional members have been improved, as well as public relations, by a carefully begun and operated program aimed particularly at the professional member relationships.

Needless to say, the agitation over compulsory prepaid medical care is affecting the acquisition program of C.P.S., but no effort is being spared to continue the expansion of beneficiary membership, pending the outcome of the present compulsory legislation.

The year 1944 and the changes introduced into C.P.S. therein had placed it in a very favorable position for rapid development. What its future is to be is undoubtedly bound up right now with the goings-on at Sacramento.

T. Henshaw Kelly, *Secretary.*

SPECIAL COMMITTEE ON MEDICAL AND HOSPITAL CARE FOR WIVES AND CHILDREN OF ENLISTED MILITARY PERSONNEL (E. M. I. C.)

Executive Group

Karl L. Schaupp, Chairman

Northern Subdivision	*Southern Subdivision*
Karl L. Schaupp, Chairman	Donald G. Tollefson
Lawrence Jacobus	William B. Thompson
Mast Wolfson	B. O. Raulston
John W. Sherrick	Charles G. Curtis
	Sam J. McClendon

George H. Kress, Secretary, ex-officio

To the President and the House of Delegates:

Commencing in California and Western Medicine in its issue for July, 1943, as per footnote in the number for February, 1944, on page 76, a large number of informative items dealing with this important incursion on the part of the Federal Children's Bureau into the domain of medical practice were called to the attention of the members of the California Medical Association. Without reserve it may be stated that the action of the special committee appointed to represent the California Medical Association, which acted in coöperation with the Bureau of Maternal and Child Welfare of the California State Board of Public Health, in calling to the attention of the Federal Children's Bureau of the United States Department of Labor certain deficiencies and inadequacies in the rules and regulations put forth by the Federal Children's Bureau, had much to do with the rectification of certain errors. It may be recorded, for instance, that the insistence of the special committee of the California Medical Association in demanding that the minimum fee for the maternity-pediatric service to be rendered by doctors of medicine to wives and infants of soldiers in the Armed Services be at least $50.00, had much to do with the establishment of that particular sum as the basic minimum standard that has since been inaugurated for other States in the Union.

Let it not be forgotten when the official representatives of the Federal Children's Bureau came to California they referred to fees of twenty-five and thirty-five dollars for all such prenatal, delivery and postnatal service, inclusive of complications! The committee of the California Medical Association insisted that such fees were out of all proportion to the worth of services rendered and insisted insofar as the State of California was concerned, that the physicians of California should not be called upon to make such donations to the treasury of the United States, even though such savings might presumably redound to the credit of a particular Bureau or Bureaucracy having its headquarters in Washington, D.C.

Many items having reference to the regulations of the Federal Children's Bureau have been considered and through direct conference by personal representatives and through indirect correspondence, were called to the attention of the Federal Children's Bureau. These problems had particularly to do with the rights of doctors of medicine in sparcely settled areas of California, where certified specialists and other accessory activities were not available, so that when these physicians were called upon to give such special service, they would receive compensation that was comparable to that granted to physicians

in the metropolitan areas. In some of these issues, the California Medical Association and the Bureau of Maternal and Child Welfare of the California State Board of Public Health were successful in bringing about remedial improvements. In others, the Federal Children's Bureau rendered the regulation negative answer so typical in these days, of many governmental bureaucracies.

From the beginning, the members of the California Medical Association announced their willingness to fully coöperate in the basic objectives of giving to the wives and infants of men in military service all adequate professional care. The controversial issues did not arise about the objectives, but on the contrary, dealt with the unlooked for and unnecessary directives, rules and regulations propounded by a small group of executives in one of the subdepartments of the United States Department of Labor.

Little more need be said, other than to add that the principles involved are of such a nature that the battle must be carried on to bring about an adjustment, so far as compensation for work rendered is concerned, that will not be a below-cost standard, when in other wartime endeavors dealing with supplies or manpower services, all else seems to be adjusted on a cost-plus basis.

Respectfully submitted,
George H. Kress, *Secretary.*

LIAISON REPRESENTATIVE TO CALIFORNIA VETERANS' COMMITTEE

To the President and the House of Delegates:

Governor Earl Warren on October 30, 1944, appointed a California Veterans' Committee under the chairmanship of William T. Sweigert to centralize affairs relating to returning California veterans. In February, 1945, Dr. Goin asked me to serve as a liaison between this Committee and the California Medical Association.

I have attended two meetings of this group and have discussed matters with them pertaining to the part which private physicians can play in helping to rehabilitate veterans. Physicians, particularly psychiatrists or those interested in psychiatric problems, may be asked to serve on local committees in order to advise and counsel returning veterans.

Respectfully submitted,
Frank A. MacDonald, *C.M.A. Representative.*

PROFESSIONAL ADVISORY COMMITTEE TO THE BUREAU OF VOCATIONAL REHABILITATION

Executive Group

John W. Cline, Chairman

J. B. Harris — Gertrude Moore
E. Vincent Askey — L. C. Kinney

To the President and the House of Delegates:

The Professional Advisory Committee to the Bureau of Vocational Rehabilitation with reference to the Physical Restoration Program has been augmented during the year.

On two occasions, it has met with representatives of the Bureau and has found them most coöperative. Where possible under the law, the Bureau has followed the advice of the Professional Advisory Committee.

Important measures relative to the program have been discussed during the past year. Principal among these have been the economic eligibility on standards to be applied to clients, the creation of a fee schedule and the method of compensation for hospitalization.

An Executive Committee of the Advisory Committee was formed at the request of Mr. H. D. Hicker, Chief of the Bureau for immediate consultation in the event of urgent problems which would require immediate solution arising. The Executive Committee is to consist of Dr. LeRoy Abbott, Mr. Butler and the Chairman.

A number of meetings of the entire Advisory Committee are contemplated during the succeeding year.

Respectfully submitted,
John W. Cline, *Chairman.*

COMMITTEE ON POSTWAR PLANS OF MEDICAL SERVICE AND SOCIAL SECURITY

Executive Group

Dewey R. Powell, Chairman

Donald Cass — John W. Green

To the President and the House of Delegates:

The members of the committee on postwar plans of medical service and social security have had no formal meeting during the year. However, the need of special study and planning is important. The House of Delegates may well consider the scope of work to be done.

Respectfully submitted,
Dewey R. Powell, *Chairman.*

LIAISON COMMITTEE OF SIX ON MEDICAL AND HOSPITAL SERVICE PLANS IN CALIFORNIA

Executive Group

John W. Cline, Chairman

L. A. Alesen — R. Stanley Kneeshaw
Mr. J. V. Buck — Mr. W. P. Butler
Mr. A. E. Maffly

To the President and the House of Delegates:

Your Committee has met at intervals with a similar Committee of the Association of California Hospitals, consisting of J. V. Buck, Chairman, and Mr. Maffley of Berkeley, and Mr. Butler of San Jose.

The effort of the joint Committee of Six has been to secure a Statewide Blue Cross Plan which could furnish hospitalization for California Physicians' Service, as well as hospitalization insurance for such subscribers as wished this service alone.

On several occasions, it has seemed probable that the objective would shortly be reached but each time considerations of various sorts have resulted in its deferment. It now appears probable that a unified Statewide Blue Cross Plan will shortly be developed. It is sincerely hoped that no circumstances will arise to prevent this development.

Respectfully submitted,
John W. Cline, *Chairman.*

COMMITTEE RE: PROPOSED CHANGES IN THE INDUSTRIAL ACCIDENT COMMISSION FEE SCHEDULE

Executive Group

Nelson J. Howard, Chairman

The following is a report of a sub-committee meeting of February 7, 1945, at which were present the following: Mr. Quigley of the California Indemnity Exchange, Dr. Lester I. Newman, Medical Director of the California State Compensation Insurance Fund; and Nelson J. Howard, representative of the California Medical Association. This committee was appointed by the Industrial Accident Commission study committee now meeting on medical fees.

The group discussed and looked over fee schedules for eighteen different states which have Industrial Accident Fee Schedules from which information had been received in reply to a questionnaire sent out.

Mr. Quigley and Dr. Newman maintained that fee schedules should take into account the yearly earnings of the average worker. In 1921 and 1922 this was estimated to be in the neighborhood of $1,250.00 per year. It is estimated by Dr. Newman that the average earnings now in 1944-45 are in the neighborhood of $1,920.00 to $2,000.00 per year. This is over 53 per cent increase and yet the argument is made that even a 15 per cent fee schedule increase is too much.

Mr. Quigley broached the question of a flat fee schedule for surgical procedures to include all pre- and post-operative care. I stated that I was sure the physicians of California would not accept a flat fee Industrial accident schedule.

It was mentioned that one must consider fee schedules in states which compete with California manufacturers. I stated that (1) we cannot lower our present standard of medical care. If anything, it must be raised. (2) The wages of California workers are not lowered to meet the wages paid in competing states.

A further meeting is planned after an opportunity to study the fee schedules of the eighteen states reporting.

Respectfully submitted,

Nelson J. Howard, *Chairman.*

REPORT OF THE LIAISON COMMITTEE WITH THE A.M.A. COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Executive Group

D. H. Murray, M.D., Chairman George H. Kress, M.D.
Mr. John Hunton

To the President and the House of Delegates:

This committee was appointed several months ago at the request of the A.M.A. Council on Medical Service and Public Relations as a means of forming a nucleus in the California Medical Association for the benefit of the national program of the A.M.A. Council. The committee has been called upon on several occasions to express the views of medicine on various national legislative proposals; these requests have been promptly and properly met.

Fortunately, it has been possible for the C.M.A. to place at the service of the A.M.A. Council on Medical Service and Public Relations the facilities of the Washington office of the United Public Health League. Through this office it has been possible to make direct contacts in Washington in furtherance of national programs in the interests of the medical profession.

Respectfully submitted,

Dwight H. Murray, *Chairman.*

Vitamin Preparations

Attention should be called to at least two of the reports concerned with vitamin preparations, namely, the status report giving the Council's decision that the evidence does not yet warrant the acceptance of cod liver oil preparations for external use, and the report announcing the Council's recognition of the use of massive doses of vitamin D in arthritis, and in this volume includes a current comment from the *Journal*, titled, "Hope (false) for the Victims of Arthritis," which reëmphasizes this objection.

The status report on xanthine compounds gives a much needed delimitation of the therapeutic claims that may be recognized for aminophylline and its related xanthine derivatives. Of similar interest is the report on the local use of sulfonamides in dermatology, and in the same category may be mentioned the report on agents for the treatment of Trichomonas Vaginitis, which points out that the present aim should not be for new medicaments in this field but for further information, especially concerning failures with those that have been used. In another status report the Council sets forth its conclusion that present evidence does not justify claims for advantage of oral use of sodium sulfonamides over the free drug. . . .

It cannot be too often said that this volume, as well as the other publications of the Council, remains of paramount interest to all who are concerned with rational use of therapeutic agents.

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties.

Herbert A. Johnston, Anaheim, *Councilor.*

Imperial County Medical Society

Meetings of the Imperial County Medical Society are held on the second Tuesday of each month in the Callfornia Hotel in El Centro. Meetings have been discontinued until fall. However, special meetings may be called at any time if anything important comes up for discussion. We have lost so many doctors to the armed forces that it has been found very difficult to get a quorum together so that any business may be conducted. We have found a better response to call meetings for discussion of any special matter which may arise.

T. E. Bartholomew,
President.

Orange County Medical Association

Dr. Frank M. Patterson, active in Orange County Practice of Medicine since 1924, died January 3, 1945. Dr. Dean C. Brown of Santa Ana, active in eye, ear, nose and throat practice, passed away February 24, 1945.

Several others of our members have been compelled to sharply reduce their practices and still others are finding it necessary to take longer vacations to maintain their strength. However, our doctors are quietly endeavoring as individuals to keep the faith and care for as many people as possible regardless to do their duty and a little more. All our doctors are finding themselves more than a little tired.

Active membership now is 96.

As one contemplates the unselfish consecration to duty of this great group of doctors who are carrying on even when suffering physical exhaustion or illness, a certain contempt arises in our hearts for those politicians who take such a time to give doctors a stab in the back and maliciously tell the whole world what failures they are.

Russell I. Johnson,
Secretary.

Riverside County Medical Association

The association meets the second Monday night of every month in the Riverside Community Hospital. The program is usually of a scientific nature and is followed by the business session of the association. A bulletin is issued by the secretary the first of the month and is generally sent out a few days before the regular meeting.

The Riverside County Medical Association has a very active membership and has done a large amount of work educating the residence of Riverside County on the Health Insurance Plans.

W. K. Templeton,
Secretary.

San Bernardino County Medical Society

The San Bernardino County Medical Society now has a membership of one hundred eighty-two members, forty-five of these serving in the armed forces. One of our members, R. C. Green, has returned from service with a medical discharge, and is again practicing in San Bernardino.

We have added eight new members during the past year, and have lost three by transfer and one by death.

Regular meetings of the Society are held on the first Tuesday of each month, October to June, both inclusive. Attendance has improved somewhat, owing to the interest of the members in the compulsory health legislation. Several meetings have been held regarding this and the discussions have been lively.

Owing to lack of gas and time on the part of the medical men, no postgraduate meetings have been held during the past year.

Arthur E. Varden,
Secretary.

San Diego County Medical Society

Activities of our local society have continued at the usual rate with the pressure of work continuing in this center of intense war material production. Twenty-six new members have been admitted and quite a list of applicants are yet to be acted on. The Council has initiated

a new procedure whereby those applying for membership present their applications in person to that body before the Membership Committee receives them. This gives the Council an opportunity of meeting the newcomers and becoming acquainted with them, and vice versa.

The Society has resumed its monthly dinner meetings with a resultant doubling of the attendance, programs being presented by leaders of the profession from outside the county. The staff of the local Naval Hospital has been of great assistance in this matter.

More active participation in the question of medico-legal problems is being taken with the appointment of a very efficient committee, under the leadership of Dr. H. C. Cornell.

Emergency Medical services lagged somewhat for a time, but interest is being revived, with some reorganization on a permanent disaster basis and closer coördination with the Red Cross. While we have not forgotten the danger of belligerent action, we are taking into account more and more the needs that will arise in case of "natural" catastrophies, fire, earthquake, etc.

A quiet campaign in favor of C.P.S. is being carreid on with a very satisfactory increase in the number of professional members, thus replacing those who have been called into service. The recent establishment of a local district office of C.P.S., with a full time staff will he of great service in ironing out problems.

W. H. Geistweit, Jr.,
Secretary.

SECOND DISTRICT

Los Angeles County.
Donald Cass, Los Angeles, *Councilor.*

Los Angeles County Medical Association

The fourth year of the war finds the Los Angeles County Medical Association playing a greater part than ever before in matters of community concern and, although severely handicapped by lack of personnel, has succeeded quite well in meeting its obligations to the membership and to the public at large.

Among the major public relations activities before the question of compulsory health insurance broke upon us a few months ago, was a series of thirteen joint meetings with members of the Bar Association. These meetings were held at the Elks Temple during the fall and winter months. Programs of importance to attorneys were presented by the various specialty sections. The result has been a much better understanding on the part of the Bar Association of the problems affecting medicine, especially those problems dealing with malpractice and with other problems that today affect professions generally.

These meetings were arranged by the Committee on Medical Defense, Doctor Louis J. Regan, Chairman, Doctor Fred B. Clarke and Doctor J. Severy Hibben, together with a Special Committee of the Bar Association, Messrs. Murray F. Keslar, John P. McGinley and E. H. Tilson, and were splendidly attended.

Following the meetings with the Bar Association there came into existence a Professional Coördinating Council, members of which represent the various professions in Los Angeles County. Problems affecting professional men are given serious consideration by this Council with the belief that on such matters united action can be brought into play.

The old wartime problems that existed last year have been with us during the present period and have been met by our committees on food rationing and gasoline rationing, which committees have maintained pleasant relationships with the various Federal boards in this area.

The Committee on Procurement and Assignment has remained a definite full time working part of our organization, with offices in our headquarters open every day in the week.

The Association, its branch officers, its public relations committee and all interested members have been exceedingly active during the past several months in an educational campaign to apprise the people of this area of the facts relative to compulsory health insurance. Major organizations have learned what compulsory health insurance means. The facilities of our Speakers' Bureau have been used to the utmost and I believe with pronounced results. Every possible avenue of approach to the people has been utilized—the press, the radio, open forum debates, and direct talks. The office has sent a great amount of literature to members wishing to distribute it, and it is my belief that this work has proved quite effective.

E. T. Remmen,
Secretary.

THIRD DISTRICT

Inyo-Mono Counties, Kern, San Luis Obispo, Santa Barbara and Ventura Counties.
Harry E. Henderson, Santa Barbara, *Councilor.*

Kern County Medical Society

The Kern County Medical Society, meeting every third Thursday except during June, July and August, at a dinner session at the Bakersfield Inn, enjoyed an active year under the presidency of Dr. H. A. Rivin.

Dr. Sophie L. Goldman, vice-president, was again drafted to the secretaryship in the absence of Dr. J. E. Vaughan, now with the armed forces.

The quality of the programs under Dr. William MacDonald remained high, despite difficult traveling conditions. Well-qualified specialists generously provide programs for the Society.

Problems which took up the major part of the attention of the members this year included:

(1) The 15 per cent surcharge levied on the insurance company fees.

(2) The resolution adopted by the Society whereby the obstetrical consultants appointed by the Public Health Service under the auspices of the Emergency Maternal-Infant Care program agreed to resign from their capacities as consultants, inasmuch as there were no specially qualified specialists in the County to serve in this capacity; this action on the part of both the Society and the local consultants being undertaken to preserve the equable relations among the members of the County Medical Society.

(3) The results and significance of the survey conducted for the California Medical Association hy the firm of Foote-Cone and Belding on the temper of the public regarding future types and plans of medical service.

Membership in the Society for the year totaled seventy-eight, with twenty-one physicians being in the Armed Forces.

Dr. H. A. Rivin served as president, with Dr. Sophie L. Goldman acting as both president-elect and secretary-protem. Board members were: Doctors Lucille B. May, C. I. Mead, L. C. McLain, J. Headen Inman, J. M. Nicholson, Keith S. McKee, and Harry Lange. Delegates: Drs. Wm. Moore and Francis Gundry. Alternates: Drs. Sophie L. Goldman and J. Headen Inman.

Juliet Thorner,
Secretary.

San Luis Obispo County Medical Society

The San Luis Obispo County Medical Society held twelve meetings during the year 1944. Twenty-five members paid dues in 1944. There are now twenty-three active members—two members having been lost by death in 1944, Dr. Henry F. Sawtelle of Arroyo Grande, and Dr. Ira Bartle of San Luis Obispo passing away after long and active lives in general practice. One member, Dr. F. F. O'Reilly, entered the armed services. There are now five members of this Society in the armed services: Doctors Charles R. Kennedy; Newell Nay; Elmer M. Bingham; Albert Shershow and F. F. O'Reilly.

Doctor W. D. Butler has returned to civilian practice after serving in the U. S. Army. No new members were elected to membership during the year 1944. There are at the present time only two practicing physicians in the County who are not members of the Society.

G. D. Kelker,
Secretary.

Santa Barbara County Medical Society

The Santa Barbara County Medical Society has an active membership of 129, of whom 40 are in the Armed Forces. Regular meetings are held on the second Monday of each month (except July and August), at 8:15 p.m., at the Bissell Auditorium of the Santa Barbara Cottage Hospital. It is the policy of the Society to have prominent members of the medical profession from outside of Santa Barbara present papers at each meeting.

The annual meeting was held January 8, 1945, at the University Club. Forty-five members and fourteen guests attended.

Guest speakers during 1944 were:

February: Dr. Walter R. Treadway, Medical Director of the United States Public Health Service, "Principles of Psycho-Somatic Medicine."

March: Dr. Walter R. Treadway, President of the Los Angeles Heart Association, "Congenital Heart Disease Readily Diagnosed." Also: Dr. Louis E. Martin, past president of the Los Angeles Heart Association, "Some Newer Aspects of Rheumatic Fever."

April: Mr. Wm. G. Ebersole, "Confidential Report of the Public Opinion Survey Prepared for the C.M.A., Dealing with the Status of the Medical Profession in California."

May: Dr. Edward S. Lamont, Hollywood, Calif., "Principles of Plastic Surgery About the Head and Neck."

June: Col. David L. Reeves, M.C. of Hoff General Hospital, "Intervertebral Disc Injuries and Disabilities."

September: Capt. Walter C. Martin, M.C., "Coccidiomycosis," also Major Rubin L. Gold, M.C. and Lt. Col. Ray B. McCarty, M.C., "Amoebiasis."

October: Dr. Wm. G. Kerr, "Nervous Tachycardia and Nervous Hypertension."

November: Dr. Harold Brunn, San Francisco, "The Cancer Problem" and "Progress of Medicine—Mistakes We Have Made in the Past."

December: Dr. W. Glenn Ebersole, Special Representative of the C.M.A. Council, "Current Medical Economic Topics."

Dr. Harold Sidebottom died recently, and he was remembered as one of Santa Barbara's oldest physicians, and his loss was mourned by many. He had not been in active practice for a number of years.

The Santa Barbara County Medical Society has ended a year during which there has been close coöperation among its members. There has been a fine feeling between the Society and the members of the community, and many of the doctors are engaged in civic duties through their membership in service organizations.

CHARLES A. PREUSS,
Secretary.

Ventura County Medical Society

The Ventura County Medical Society has a total membership of fifty-two. Nineteen of these are inactive because of military service.

Meetings are held on the second Tuesday of each month at the Ventura County Country Club at Saticoy. An excellent dinner precedes each meeting. Members rotate in serving as program chairmen. The scientific meetings have included interesting and instructive motion pictures as well as lectures by prominent outside men and members of the Society.

As elsewhere, there is a shortage of medical personnel and hospital beds, but the fine coöperation shown by the doctors and hospitals has minimized the heavy burdens of wartime practice.

Members of the Society are active in the American Tuberculosis Association, the American Society for the Control of Cancer as well as in civic groups for the study and control of local problems.

G. H. ARNOLD,
Secretary.

FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Jaoquin, Stanislaus, Tulare, and Tuolumne Counties.
Axcel E. Anderson, Fresno, *Councilor.*

Fresno County Medical Society

During the year 1944 the Fresno County Medical Society held ten regular meetings, July and August being observed as a vacation period.

The Society meets at the University-Sequoia Club, and our scientific programs usually consist of a talk by one of the staff members of the University of California, Stanford or University of Southern California Medical Schools.

One program each year is a joint meeting of doctors, dentists and lawyers. This program is arranged by one of the three organizations, alternating each year. This meeting is held during the month of May. The afternoon is spent playing golf, and a dinner meeting, with an outstanding speaker, is held in the evening.

The scarcity of doctors and the shortage of hospital beds have made medical care somewhat difficult. However, it is believed that adequate medical care in this community is not lacking.

K. D. LUECHAUER,
Secretary.

Kings County Medical Society

The Kings County Medical Society in 1944 had an active membership of fourteen, with no new members added. One member entered military service, and one was discharged, thus making nine members in the various branches of the service. Only two meetings were held during the year.

ARTHUR ZEISMER,
Secretary.

Merced-Mariposa County Medical Society

Following is a brief summary of the activities of the Merced-Mariposa Medical Society during the past year:

The Merced-Mariposa Medical Society has held regular monthly meetings throughout the year. Prominent speakers have addressed the group from time to time. These meetings were a combination of business and pleasure. Dinners were planned in conjunction with the business meetings, and provided enjoyable seasons of fellowship on these occasions.

C. C. FITZGIBBON,
Secretary.

San Joaquin County Medical Society

During the year 1944 we had 108 active members on our roll and of these, 40 were in military service. Three of these men have been returned to civilian life because of disability incurred during their time in service. These were Drs. B. J. Powell, Jr., P. H. McHugh and G. H. Rohrbacher. During the past year three doctors were elected to membership (T. Hill, W. C. Richli and H. K. Wilson) and Dr. W. C. Curphy was transferred from Marin County. The society lost, by death, Drs. T. R. Trick and Chas. F. English.

The meetings of the last year were held monthly at the club room of the Medico-Dental Bldg. in Stockton, except when the Society was the guest of the San Joaquin County Hospital and State Hospital.

The following programs and speakers were presented by the program committee:

January 6—"Newer Concepts in Diagnosis and Treatment on Poliomyelitis," by H. Brainerd, M.D.

February 3—"Use of the Gastroscope in the Diagnosis of Gastric Lesions," by N. C. Giere, M.D.

March 2—"Clinical and Roentgen Manifestations of Various Atypical Pneumonias; Intravenous Injection of Opaque Material in Living Person for Demonstrating Cardio-vascular Diseases; Some Conditions Leading to Gastro-intestinal Bleeding," by E. R. Miller, M.D.

April 6—"Prevalence of Cerebro-Spinal Infection in San Joaquin County," by J. J. Sippy, M.D.

May 4—"Penicillin Resistant Gonorrhea," by Col. G. Cheney and "Plastic Surgery in Wounds," by Maj. J. Pick.

June 1—"Diagnostic Problems in Brain Tumors and Treatments," by H. A. Brown, M.D.

September 6—"Electrical Shock Therapy," by E. Tock, M.D.

October 5—"Special Report from the Council of the California Medical Association," by Glenn Ebersole.

November 2—"Outlook for the Gastric Cancer Patient," by T. F. Mullen, M.D.

December 7—"Experiences in the Southwest Pacific-Medical and Otherwise," by G. H. Rohrbacher, M.D.

In addition to the above schedule meetings, the San Joaquin County Medical Society in conjunction with the San Joaquin County Dental Society and the San Joaquin Bar Association held a dinner meeting to honor John J. Sippy, who had been elected president of the American Public Health Association. In conformity with the established tradition of the Society, the gold key of the San Joaquin County Medical Society was presented to Dr. Sippy. This key is presented, as occasion arises, to members who have brought signal honor to the Society.

The San Joaquin County Medical Society has taken a strong stand in favor of the action of the House of Delegates of the California Medical Association in opposing half-baked and immature health legislation.

GEORGE H. ROHRBACHER,
Secretary.

Stanislaus County Medical Society

The year 1944, on the whole, was uneventful. The Stanislaus County Medical Society held ten regular monthly meetings, there being no meetings in the months of July and August.

About one-third of our members are in the Armed Forces.

H. R. GANT,
Secretary.

Tulare County Medical Society

Despite the wartime difficulties of travel, dinner meeting places, securing outside speakers, the Tulare County Medical Society completed an active year in 1944 under the able guidance of Dr. F. L. Wiens, President and Dr. W. A. Winn, Vice-President.

There were 42 active members in 1944, in addition to 16 members with the Armed Forces. We rgeretfully

acknowledge the death in 1944 of Dr. Reuben Hill of Exeter, California.

At the last meeting of 1944 Dr. Charles Mathias was elected president for the year 1945. The other officers were retained.

JAMES C. MALCOLM,
Secretary.

FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties.

R. Stanley Kneeshaw, San Jose, *Councilor.*

Monterey County Medical Society

Regular meetings of the Monterey County Medical Society were held the first Thursday of each month (excepting months of June, July and August). The place of meetings usually alternated between the Santa Lucia Inn, Salinas, and the Del Monte Lodge at Pebble Beach.

The roster of the Society now includes seventy-three members. Of this number, sixteen are in the Army and ten are in the Navy. Two members were lost through death, one has retired, one has transferred from the Society and one has been elected through transfer.

The Woman's Auxiliary of the Monterey County Medical Society has been most active and its continued help and assistance has been deeply appreciated.

Several scientific programs were given, as well as considerable time to the various health legislative measures. Dr. M. Merrill of the State Health Department and Commander A. Bower, U.S.N.R., gave a report on "Typhoid Fever" in June. Lt. Commander N. O'Niel spoke on "Subcutaneous Injuries of the Abdomen" in September. During October, Maj. E. Simard presented a paper on "Trauma with Reference to Gunshot Wounds." Several meetings were featured by motion pictures.

DIXI BINGAMAN,
Secretary.

San Benito County Medical Society

The past year has found no changes in our membership. We have five members in civilian practice. This county has experienced a population increase which has increased the burden of medical care. A definite shortage of nurses and hospital beds has proved more of an inconvenience than an actual hardship.

JOHN J. HARUFF,
Secretary.

San Mateo County Medical Society

The following is a report of the activities of the San Mateo County Medical Society during the year 1944:

The present membership consists of 78 active members; 6 associate members; and 26 Service members. During the year, four new and one associate member were admitted to the Society.

Monthly meetings were held in conjunction with the Mills Hospital Staff. These meetings featured case reports and clinical-pathological conferences. Several meetings were devoted to discussion of the various compulsory health insurance plans. Mr. Albee Slade of the C.I.O. was guest speaker at one of these meetings. A standing committee of six members has been appointed to study all phases of health insurance and to submit a report to the Society in six months.

Due to the pressing need of hospital beds, the unused tuberculosis pavilion of the San Mateo Community Hospital has been taken over, repainted and refurnished, and is now used as an annex of Mills Hospital. This addition makes available about thirty beds for the use of medical patients.

The Society has gone on record as opposing the admission of any physician to the Society unless he has first been cleared through both the County and State Procurement and Assignment Service.

J. PAUL SWEENEY,
Secretary.

Santa Clara County Medical Society

The Santa Clara County Medical Society now has eighty-eight members in the armed forces. There have been seven new members elected, and one member has died during the year.

Attendance at regular meetings has been increasingly good. No meetings were held in July or August.

A notable feature of the scientific meetings was a series of lectures by Dr. Alton Ochsner of New Orleans, given under the sponsorship of the San Jose Hospital Staff.

Procurement and Assignment activities have been continuously reviewed by the Council of the Society, and active coöperation with the Visiting Nurse Association and the American Red Cross has continued.

During the latter part of the year, increasing attention has been attracted to questions of the State sponsorship of prepaid medical plans as proposed for adoption by the California State Legislature. A considerable load has been carried by many individual physicians in attempting to help solve the problems presented.

FRED W. BORDEN,
Secretary.

Santa Cruz County Medical Society

Because of wartime restrictions and limitations, together with heavy professional demands on the members, only four meetings were held during 1944. Three of these were devoted to medico-economic discussions. In January a special meeting was called by President Sambuck of Watsonville for the purpose of considering the various aspects of the E.M.I.C. program. In March a meeting was devoted to a report by Mr. Ebersole who represented the C.M.A. Council for the purpose of disseminating among the members information obtained at time of recent State survey. Mr. Ebersole was with us again in November at which time he brought the members up-to-date, on matters of medico-economic importance. At the December meeting Doctor John Alden of San Francisco, was the speaker and addressed the members on the subject of "Psychiatry in General Practice." This was a very practical and instructive paper. The annual business meeting was also held at this time. Our membership, as of January 1, 1945, was 44, with 15 absent in military service. Two members died during 1944. These were Doctor F. H. Koepke of Watsonville and Doctor A. D. Garibotti of Santa Cruz.

SAMUEL B. RANDALL,
Secretary.

SIXTH DISTRICT

San Francisco County.

John W. Cline, San Francisco, *Councilor.*

San Francisco County Medical Society

Standard forms for insurance certificates have been effected and printed by your Society for distribution to its members; these forms are brief and save much work for physicians. They are almost universally acceptable and may be secured at the office of the Society.

Your Society secured the coöperation of the Petroleum Administrator to provide adequate supplies of gasoline for physicians for the maintenance of their work, so that no longer are physicians told, "no more gas," but now the reply is, "You are a physician? Yes, I have an emergency supply of gasoline for physicians."

An extremely active committee is still at work to combat the 100-125 per cent increase in premiums for malpractice insurance. From their achievements to date I can virtually promise you that conditions will be better in the future.

The plethora of registered nurses in hospitals, especially those on general duty, provoked an issue that was so great it finally broke into newspaper publicity. But your Society succeeded in enlisting the coöperation of the Nurses' Association and the hospital superintendents in the solution of this problem, and as a result, the problem is no longer acute. Our sincere thanks to the groups who have coöperated with us so well.

We are extremely grateful to the Committee on Food Rationing, under the chairmanship of Mary E. Mathes. This committee has met regularly for several hours each week throughout the year and has achieved results beyond the comprehension of most of us. To Doctor Mathes and her committee we extend our grateful appreciation.

An active campaign against the Wagner-Murray-Dingell bill in Congress was instituted in coöperation with our state and national societies. We express our appreciation to the State Chamber of Commerce which joined us so vigorously (as well as to so many other organizations) for their support.

Your Society has provided for automatic reinstatement into membership of all our physicians and surgeons discharged from active military duty.

The problem of the settlement of so many new physicians in San Francisco County has been cared for, since these men must not replace our members returning after military service, by providing that they must secure clearance through Procurement and Assignment Service before being eligible to membership in our Society.

Furthermore, we have vigorously opposed the temporary licensure of physicians in California; there are thousands of physicians in California now in military service; we feel it is our duty to replace them at home first; thereafter new needs may be provided.

The ambiguous wording in the health and accident policies of certain insurance companies has been largely overcome; no longer may policy holders maintain that their policy provides full fees to physicians. This has been clarified. It is one of our major accomplishments. Dr. Nelson Howard is chairman of your committee.

The disbanding of the San Francisco Civilian Defense Council and the task of caring for local medical disaster programs under the Department of Public Health sustained the coöperation of the San Francisco County Medical Society. Its members gladly volunteered their continued service in keeping with the age-old humanitarianism of physicians the world over.

The problem of rat control and the spread of infection from its inadequacy, led to a detailed study by your Society. It was agreed that our Department of Public Health was handicapped by the lack of sufficient funds for the employment of an adequate number of rat control forces. These conditions permitted a possible plague in San Francisco. It was our duty to help correct these conditions and active measures were instituted thereto.

There have been several attempts to obviate the Principles of Professional Conduct in relation to radio broadcasts. In each instance, the Board, the Executive Committee or the Committee on Professional Conduct has clarified the situation for our membership. As a result, not a single violation of our Principles of Professional Conduct has occurred this year. Our membership and our committees are to be commended for this.

The Gold Note Committee, under William C. Voorsanger, reports a total income of $3,250 on this year's campaign. Of this, $1,070 was donated outright to the Society, $1,020 was contributed to the Special Service Fund, and donations of 50 per cent or so made to the Society so that we saved some $562 on partial payments on purchased gold notes. Since the balance of payments on gold notes is due in 1947, our committee has done remarkably well. Our sincere thanks to its chairman and to its members.

The Irwin Memorial Blood Bank has been our pride and joy. We have done our duty to the citizens of San Francisco and we extended our surplus in extraordinary amount, principally to the Navy. In addition, our Director, Curtis E. Smith, has managed to acquire a financial surplus, the first in our Blood Bank's history. It is of good proportions, and to his directors and to his confreres we extend our sincerest congratulations. To those who have voluntereed their services (and they are mostly doctors' wives) we take off our hats, as we usually do, to these noble and irreplaceable companions.

We shall be engaged in a struggle with the Health Service System in relation to changes in the fee schedule soon. We have laid plans for a new home for our County Society. We are coöperating with the Women's Field Army of the American Society for the Control of Cancer in their efforts to establish a detection or guidance clinic for the early discovery of cancer. The foundations of these objectives are set, but extraneous conditions and your new officers, Board and committees, shall ultimately decide them. I feel you are entitled to the above data since they concern you so vitally. What I have left unsaid has constituted at least 100 per cent more of your Board's and committees' activities. Many of us have not known all that our Society has done for us in the past. I hope the present résumé will make you all more satisfied with your membership and, I hope, it will make each of you more active in your efforts for the welfare of your Society in the future.

STANLEY H. MENTZER,
President.

SEVENTH DISTRICT

Alameda and Contra Costa Counties.
Lloyd E. Kindall, Oakland, *Councilor.*

Alameda County Medical Association

The last few months of the year just past has shown a decided increase in Association activity by the members of our County, a condition which is particularly noticeable in increased attendance at our regular monthly meetings which are held on the third Monday of each month except for the vacation period of July and August.

Our programs have been devoted, both to the science of medicine and to the very important economic problems which confront the profession today. Visiting medical officers have shared the wealth of their experiences with us on numerous occasions.

Two projects for the betterment of our Association have occupied much time and attention. First, the business organization of our Association under the leadership of Mr. Rollen W. Waterson, recently of Lake County, Indiana, at present, the Executive Secretary of the Association of American Physicians and Surgeons. The second project is a plan to aid any of our members who may need help on return from military duty in establishing themselves once again in private practice.

We have found the plan to receive new comers as temporary members immediately upon establishing practice in this County a very satisfactory one. As anticipated, it has given us a splendid opportunity to learn to know these men before we admit them to permanent membership.

GERTRUDE MOORE,
Secretary.

Contra Costa County Medical Society

The following is the report of the Contra Costa County Medical Society for the year 1944. The membership totaled sixty-one members, seven being in the Military service. The latter group included Drs. P. F. Winn, G. L. Coates, H. B. Flanders, J. J. Fitzgerald, C. E. Dietderich, E. L. Huwe, and E. C. Gerou.

Nine regular meetings were held during the year, on the second Tuesday of every month; each meeting consisting of a business session and scientific program conducted by guest speakers.

The California Medical Association and California Physicians' Service coöperated to establish a fee-for-service clinic in Richmond, which has aided in solving the medical care problem in this area.

H. W. MCNERNEY,
Secretary.

EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Placer-Nevada-Sierra, Plumas, Sacramento, Shasta, Sutter, Tchama, Yolo, and Yuba Counties.
Frank A. MacDonald, Sacramento, *Councilor.*

Butte-Glenn County Medical Society

During the past year, despite our limited number, as almost fifty per cent of our members are in the Service, we have held about eight meetings, many in conjunction with the Woman's Auxiliary. Our average attendance has been 15 to 18, out of a membership of 22, ten of them residing twenty-five to forty miles distance. In connection with the Woman's Auxiliary, attendance has at times been about thirty.

Our speakers have been from San Francisco, the University of California and Stanford, and at times, some local member.

All appointed committees have functioned successfully, and on the whole we have had a husy year in every way.

About twelve men from this area are in the Armed Services, serving in the various War Theatres where our troops are located. They are serving their Country with distinction; several have children; one has two, one of whom he has never seen; another has three and a third has four, and they are or have been on the fighting fronts, but I have never heard a politician refer to them in any capacity; they are the forgotten fathers and their votes are few.

J. O. CHIAPELLA,
Secretary.

Lassen-Plumas-Modoc County Medical Society

The Lassen-Plumas-Modoc County Medical Society has had few meetings because the doctors have been unable to leave their practices for enough time to do the necessary traveling. Issues have been discussed with members by telephone as much as possible and decisions arrived at in this manner.

J. W. CREVER, JR.,
Secretary.

Placer-Nevada-Sierra County Medical Society

Because of continued war conditions and restrictions on gasoline and tires, there have been a limited number of meetings during the past year. Including the Annual Meeting of November 13, 1944, there have been four meetings in all:

1. Annual meeting of November 13, 1943: There were twelve members present. No literary program was presented but the new constitution and by-laws were discussed and unanimously adopted.

2. Meeting of February 26, 1944: Fourteen members and the guest speaker, Dr. Frank Reardan, were present. Dr. Reardan's subject was "Electro-Cardiography." In addition to the regular business which came before the members, the following Board of Directors was elected: For Placer County: Dr. Robert H. Eveleth and Dr. J. A. Russell. For Nevada County: Dr. Vernon W. Padgett and Dr. B. W. Hummelt. In addition to the four above named, the President, Dr. George Foster; the Vice-President, Dr. Paul D. Barnes and the Secretary-Treasurer, Dr. Robert A. Peers, made up the Board of seven members.

3. Meeting of July 14, 1944. This was a dinner meeting, members being guests of the professional staff at DeWitt Hospital. There were eighteen members present.

4. Meeting of September 12, 1944. This was a special meeting called for the purpose of hearing Mr. W. Glenn Ebersole, special representative of the C.M.A. Council. There were sixteen members present and the only visitor was the speaker, Mr. Ebersole. No other program was presented.

The membership of the Society is now thirty-eight. During the year we have lost two members by death—Dr. Carl Power Jones, Grass Valley, and our Retired Member—Dr. D. D. Johnson, also of Grass Valley. One member resigned during the year and we acquired one new member—Dr. George G. Stauch, of Weimar. At the present time there are ten members in the Service. One member, Dr. Robert A. Peers, has acquired a Life Membership thus leaving twenty-seven paying members.

VERNON W. PADGETT,
Secretary.

Sacramento Society for Medical Improvement

The Sacramento Society for Medical Improvement meets at 8:30 p.m. on the third Tuesday of each month in the auditorium of the Nurses' Home at Mercy Hospital, 40th and J Streets. No meetings are held during the vacation months of July and August. Programs are arranged by a committee, and the December meeting is devoted to Society business and the election of officers for the ensuing year. No bulletin is published by the Society, but the programs of the meetings are announced on printed notices which are sent to all local physicians and other interested physicians in nearby communities. Notices of the monthly meetings are also sent to physicians in Military Service at the adjacent Army posts. The following speakers and programs were presented during the year:

January 18—Officers of the Hammond General Hospital presented the program:

Lt. Col. G. S. Reynolds, "Gunshot Wounds." Capt. W. L. Noe, "Filariasis-Present Day Status." Lt. Col. Garnett Cheney, "Problem of Relapsing South Sea Malaria."

February 14—Officers of the U. S. Naval Hospital of Oakland, Calif., presented the program:

Commander Paul Michael, "Filariasis." Lt. Comdr. D. L. Wilbur, "Clinical Problems in Tropical Medicine." Lt. Albert C. Daniels, "Penicillin." Lt. Comdr. P. W. Greeley, "Plastic Repair of Extensor Contractures of the Hand."

March—Annual Banquet at Sutter Club.

April 18—Mr. Glenn Ebersole discussed the report of Foote, Cone, and Belding.

May 16—Meeting held at Camp Kohler, the program being given by members of the Staff of the Station Hospital.

September 19—Meeting held at McClellan Field, the program being given by several members of the Staff of the Station Hospital.

October 17—Officers of DeWitt General Hospital, presented the program:

Major John Dry, "Cardiac Emergencies." Capt. Francis Echlin, "Diagnosis and Treatment of Head Injuries."

November 21—Officers of the Oak Knoll Naval Hospital presented the program:

Capt. W. F. Bueerman, "Surgical Management of Arteriovenous Aneurysm following Combat Injury." Comdr. Jesse T. Nicholson, "The Treatment of Compound Fractures Received in Battle."

December 19—Annual Business Meeting with election of officers.

The Society has a membership of 178, of whom 51 are in the Armed Forces, and one is an Honorary member. One member, Dr. W. R. Briggs, died while in the service of his Country.

EDMUND E. SIMPSON,
Secretary.

Shasta-Trinity County Medical Society

The Shasta County Medical Society has an active membership of seventeen. During the year of 1944, there were four members who transferred to other counties. Eight other members are in the Army.

The old St. Caroline's Hospital is now under the management of the Sisters of Mercy from Sacramento and is known as Mercy Hospital.

The Shasta County Medical Society meets regularly on the second Monday of each month except during June, July, and August. The Society has unanimously moved to adopt the proposed fee schedule by the California Medical Association for industrial accidents.

JULIUS M. KEHOE,
Secretary.

Tehama County Medical Society

The Tehama County Medical Society at its regular meeting, the evening of March 14, 1945, elected the following officers for the year 1945. President, James L. Faulkner, M.D., Vice President, H. H. Beck, M. D., Secretary and Treasurer, R. G. Frey, M.D. Delegate, R. G. Frey, M.D., Alternate, F. L. Doane, M.D. Dr. O. T. Wood, who is in the Navy is now in the South Pacific. The Society is taking active part in the campaign against State Medicine.

R. G. FREY,
Secretary.

Yolo County Medical Association

During the past calendar year the Yolo County Medical Society has continued to be very active. We have been fortunate to obtain unusually good speakers for our programs and our attendance has been very good. The meetings have consisted of a scientific discussion on each occasion. The speaker, without exception, has given an interesting and worthwhile address. Our total number of active members at present is sixteen, while the number of members in the Military Service is twelve.

The care of the farm crops requires an influx of approximately 5,000 workers. These are made up of Mexican Nationals, Navajo Indians and migratory workers. The medical expense for the Indians and Mexican Nationals is borne by the Agricultural Workers Health and Medical Association. These workers are most important to our farmers and without them much of our land would have to remain idle or be diverted to crops which require little labor. These latter crops are not especially needed during the current food shortage. The Society members are thus very willing to have this additional burden. At times, however, it is quite trying because of the language difficulties.

EMERY LEIVERS,
Secretary.

Yuba-Sutter-Colusa Medical Society

Nine regular meetings were held in 1944, on the second Wednesday of each month at the Marysville Hotel. No meetings were held in July, August, and September.

Dr. Russel Frantz served as program chairman and several excellent programs were given including a talk on Allergy by Col. Berkhove of Camp Beale. The meetings were open to medical officers of Camp Beale.

The roster of active members—now 17 mmebers—12 members are in the armed forces. Two new members were added during the year. Dr. T. F. Keyes, Surgeon of Marysville Clinic, and Dr. P. J. Cress, who succeeded Dr. E. E. Gray.

Death took Dr. G. W. Stratton, who had practiced fifty years in the locality.

T. F. KEYES,
Secretary.

NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties.

John W. Green, Vallejo, *Councilor.*

Humboldt County Medical Society

For the year 1944 the Humboldt County Medical Society had a paid up membership of twenty-five. One of our members, Dr. Lane Falk, moved to Modesto and Dr. Eugene V. Falk of Modesto returned to Eureka. Dr. Jacob Reicher of New York City is also establishing a practice in Eureka, and Dr. Wayne McKee opened an office for the general practice of medicine in Ferndale. Outside speakers were obtained by President Carl Wallace for five meetings during the year.

The older doctors have been burdened with an unusual amount of work because of the increased industrial activity at a time when so many of the young physicians are in the armed services.

The Humboldt County Medical Society recommended the employment of a full time health officer for this county but political and legal complications have so far prevented any action.

California Physicians' Service sent in a sales force and a large number of groups are now covered for medical and surgical service under this splendid voluntary plan.

J. S. Woolford,
Secretary.

Marin County Medical Society

The Marin County Medical Society had a most satisfactory year in 1944. The present number of members is 34. One member retired because of ill health and two new members were accepted, one from the military service. The other a new member. Of the 19 members in the Services, two have been transferred to other societies, the 17 are carried as active members. There have been no deaths in our society in the past year. Eight regular monthly meetings were held with the average attendance of 18 (several members did not appear more than once which brought down the average attendance). The programs were interesting and worthwhile; a healthy coöperation continues to exist.

The Doctors have been very busy but have complained very little. The nursing situation in the County has gradually become worse. At present nurses are at a premium and there is no prospect of any improvement in the future. The two hospitals in the County have done a good job. They are always willing to coöperate.

Obstetrical situation has been well taken care of, even if it has been necessary to sometimes send the new mothers home on the third day.

Carl W. Clark,
Secretary.

Mendocino-Lake Counties Medical Society

During the year 1944, there were 18 members in the Society in addition to 10 members who are in the armed forces. Our meetings were held at three month intervals. The last two meetings dealt largely with the discussion of the compulsory health bills before the Legislature.

Mr. Louis LaGrave, representative from the home office, was the speaker at our last meeting and gave us much needed information regarding the future practice of California Physicians' Service.

Dale E. Barber,
Secretary.

Napa County Medical Society

It was rather difficult to hold regular meetings of the Napa County Medical Society during the year of 1944 due to the press of professional duties on the part of the medical men left in Napa County. However, meetings were held almost monthly with our membership of thirty-two. We had our usual Annual meeting at the Napa State Hospital and Veterans Home with large attendance and interesting and instructive programs. Several of our meetings consisted of reports from various groups relative to the State Health Bill with good discussions. We have many men from our Society now serving in the Armed Services and it is with regret that we are not able to list them and their whereabouts in this issue, however, our record regarding them is inaccurate due to the constant changes of addresses.

Our present officers for the year 1945 are: President, Charles Caulkins, of Imola; Vice President, Orville Kirkle, of Napa; Secretary and Treasurer, M. M. Booth, of St. Helena; Delegate, Dwight H. Murray, of Napa; and Alternate, R. C. Burkett, of Napa.

Our next monthly meeting is to be held at the Plaza Hotel, in Napa, April 4th, with our guest speaker, H. Claire Shephardson, of San Francisco.

M. M. Booth,
Secretary.

Siskiyou County Medical Society

The membership of our County Society is now only ten, with one new application under consideration. We are widely spread out in the State's second largest county and it is increasingly difficult to assemble for regular meetings. Nevertheless, we country physicians have the double advantage of being very close to each other professionally and in our efforts in achieving the highest possible standards for medical practice; and of being close to our patients, who, we feel it is not presumptive to report, are in a very high percentage favorably inclined in our behalf.

F. W. Martin,
Secretary.

Solano County Medical Society

A review of the activities of this Society for 1944 follows:

On January 11, 1944, Dr. Seymour M. Farber of the University of California addressed the group on "Atypical Pneumonia." He illustrated his subject by showing many interesting x-ray films. It was an excellent meeting.

Upon the request of members of the Board of Trustees of the Vallejo Community Hospital, which contemplates opening for reception of patients in March, Dr. H. Randall Madeley was chosen Chairman of the Staff for the first year of operation.

The second meeting of the year occurred on February 8, 1944, at the Astor House and following an excellent dinner, Dr. Kessler (Capt. Medical Corps, U.S.N.R.), of Mare Island Hospital, addressed the Society on "Amputations of the Extremities." Dr. Kessler received much applause and commendation for his presentation. C.P.S. was invited by the Society to sell its surgical contract in the Vallejo area.

The March meeting was delayed until March 29, 1944, and was held at Vallejo Community Hospital. The business of the evening consisted of a review and adoption of a constitution and by-laws, and selection of the Chairmen of the various services of the Hospital.

On April 11, 1944, members of the Society were addressed by Dr. Clifford Swett, Dr. Albert Rowe and Dr. Helen Johnson. The professional program was preceded by a dinner at the Astor House. The meeting was well attended. Dr. Rowe spoke on "Abdominal Allergy." Dr. Johnson discussed "Abdominal Pain in Rheumatic Fever," and Dr. Swett carried on with "Differential Diagnosis of Abdominal Disease in Children." The sum of $1,000.00 was voted by the Society to establish a County Medical Society Library to be placed in the Vallejo Community Hospital. A file of letters concerning the history of attaining the Vallejo Community Hospital was turned over to the Secretary. This may be interesting in future years.

One June 13, 1944, following a dinner at New Tiny's, Dr. Rosenbloom addressed the group on "Rheumatic Fever." The dinner was not so good, but the professional program was excellent. This meeting was well attended.

There was no meeting in July, but on August 8, 1944, Dr. William K. Livingston, U.S.N., spoke on "Injuries to Peripheral Nerves" at the Board Room of Vallejo Community Hospital. C.P.S. reported that Surgical contracts had been sold in Vallejo and at Benicia Arsenal.

On September 12, 1944, Dr. Hub Isaacs (M.C.) U.S.N.R., Mare Island Hospital, spoke on "Plastic Reconstruction of the Ureter." California Physicians' Service reported that there was a steady decline in beneficiary memberships.

The October meeting, on the evening of the 10th, was addressed by Dr. Gerald O'Connor (Lt. Com. U.S.N.R.) stationed at Mare Island Hospital. His subject was "Immediate Treatment of Acute Injuries." His presentation was highly commended. A movie was shown illustrating the making of an artfiicial thumb.

In November the annual election of officers resulted in selection of Dr. H. Randall Madeley to succeed himself as President. Felix Rossi, Fairfield, Calif., Vice President. Secretary-Treasurer, John W. Green. Delegate to C.M.A. House of Delegates, Dr. H. Randall Madeley. Alternate, Dr. F. Burton Jones.

The annual Christmas party was not held. In previous years a Josh motive was carried out and it has not been customary to have a professional program.

Membership in the Society has been increased by three physicians coming in from other County Societies. No deaths during the year. Dr. Dempsey and Dr. Petersen have recovered from severe illness. Two physicians left C.P.S. and opened offices for private practice in Vallejo.

John W. Green,
Secretary.

Sonoma County Medical Society

The membership of the Sonoma County Medical Society is 75 at the present time. Two new members were added to the roster during the year. There are now 20 members in the Armed Services. There have been no resignations or transfers, nor were there any deaths.

The meetings have been held the second Thursday of

each month, at which time various medical and surgical subjects were presented by guest speakers. One special meeting, on March 25, 1944, was a closed meeting, during which we heard Mr. Ebersole speak on the subject of the recent Foote, Cone and Belding Survey.

This Society was host at a joint meeting of the Sonoma, Marin, Napa, Solano, Mendocino, Humboldt, and Lake County Societies, held at Guerneville, October 12, 1944. The dinner and evening meeting was preceded by a golf tournamnt. The speakers of the evening were Dr. Green, of Vallejo, Councilor for this area, Dr. Dwight Murray, Chairman of the Legislative Committee of C.M.A., and Mr. W. Glen Ebersole.

During this past year we have initiated the practice of issuing a bulletin which contains an outline of the guest speaker's talk, and also contains a résumé of the business transacted.

ROBERT S. QUINN,
Secretary.

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Association of American Physicians and Surgeons*

(COPY)

Gary, Indiana, 504 Broadway, November 17, 1944

Dear Doctor:

This is a call for action to prevent the imminent regimentation of medicine.

The 1944 elections have swept away every hope that the free and private practice of medicine will not be replaced by a system of state medicine unless physicians take immediate action to prevent that national catastrophe.

The author of the American system of political medicine, Senator Wagner, has been reëlected. The Political Action Committee of the CIO, which demands socialized medicine, has been so successful that it has become tremendously powerful—certainly powerful enough to translate its program of state medicine into legislation. Medical care is next on the calendar of the congressional

* The letter printed above is given place in CALIFORNIA AND WESTERN MEDICINE because some of the statements contained therein are worthy of consideration; as were also the Northern California Union Health Committee *"News Letter,"* which appeared in the November issue of CALIFORNIA AND WESTERN MEDICINE, on page 261.

majority that believes it was elected because of its social "achievements."

It is now later than you think!

The Association of American Physicians and Surgeons was organized in 1943 to meet this grave emergency. Its members contract and agree with each other that they will not participate in schemes for the distribution of their services that are considered by the Association to be inimical to the public health. Therefore, when a majority of physicians become members of the AAPS, there can be no regimentation of medicine. . . .

Simple Logic

Reduced to the simplest syllogistic form, the AAPS reasoning is as follows:

State medicine is a system that operates to distribute medical care;

Medical care cannot be distributed without the participation of physicians;

Therefore a system of state medicine cannot operate without the participation of physicians.

The courts have always upheld the right of an organization of individuals to do whatever an individual may lawfully do. Even the Wagner-Murray-Dingell Bill respects the right of the individual physician to refuse participation in its scheme for state medicine. It makes provision only for our voluntary participation. Hence:

An individual physician may lawfully refuse to participate in a system of state medicine;

An organized group may lawfully do anything an individual may lawfully do;

Therefore physicians as an organized group may lawfully refuse to participate in systems of state medicine.

And test this:

Systems of state medicine require more medical service and therefore more physicians than systems of private practice;

There are not more than enough physicians to supply the services required under the present system of private practice;

Therefore a system of state medicine would require the participation of at least a substantial majority of physicians.

Final conclusion, based upon the above conclusions:

Physicians may lawfully organize to refuse participation in systems of state medicine, which cannot operate without the participation of at least a majority of physicians;

The AAPS is an organization of physicians who contract and agree not to participate in systems of state medicine;

Therefore when a majority of the physicians of the nation become members of the AAPS, systems of state medicine cannot be operated.

Act Now

Act Now! This may be your last chance. The AAPS is the only tangible, positive defense you have against a bureaucratic control of your patients and your own professional life. If you agree in principle with the purposes of the Association, join now and vote later to change minor details with which you may disagree. Remember that you will have no vote in a system of political medicine.

We recommend:

1. That you sign the enclosed application blank and mail it with your check at once. We need both your membership and your money.

2. That you write for additional application blanks and enlist the support of your colleagues. Don't hand the blanks to them to sign and mail, but get the signatures and their checks and mail them to us yourself.

3. That you come to the headquarters office and investigate the organization yourself, as others have done, so that you may report accurately to your colleagues.

4. That you organize a meeting of your county or district society and invite a representative of the AAPS to discuss the Association with you.

5. *That you act now, immediately, before it is too late.*

Literature

New literature regarding the Association of American Physicians and Surgeons is being rushed to the printer. Decisions reached at the annual meeting in August and the modification of the controversial "75 Per Cent Rule" are included and will be sent to you upon request, if it is not then too late. If you have misplaced your copy of the *News* of the Association, which contained the Articles of Incorporation and By-laws, others are available and will be sent to you.

A. J. Sullivan, M.D., *President,*
H. W. Detrick, M.D., *Secretary,*
Association of American
Physicians and Surgeons.

Remember! The first successful regimentation of any group means the end of free government.

* * *

Questions Most Frequently Asked About the AAPS:

Who is behind it? It was organized by the members of the Lake County Medical Society (Indiana). It now has members in every state in the Union. Only members of county medical societies are eligible for membership. Its present officers are Dr. A. J. Sullivan, President (Secretary, Englewood Branch, Chicago Medical Society); Dr. H. T. Low, Pueblo, Colorado, President-elect (Secretary, South Central Section, American Urological Association); Dr. H. W. Detrick, Hammond, Indiana, Secretary (Past-President Lake County Medical Society); Dr. Walter S. Fisher, Columbus, Indiana.

* * *

Is the premise, that doctors may organize to refuse participation in system of state medicine, legally sound? How about the "restraint of trade case?" Our legal counsel, who is well known to the American Bar and is a past-president of the Indiana State Bar Association, assures us that there can be no question regarding the right of individuals to organize for the purpose of refusing to participate in any kind of program. Medical societies throughout the country have been asked to submit his opinions to their own legal counsel, and there have been no disagreements.

* * *

Is the AAPS a "doctors' union"? The comparison of the AAPS with labor unions is a fraud perpetrated by its opponents. Labor unions use the strike against their employers to gain their objectives; the employer of the physician is his patient, against whom he will never "strike." The AAPS refuses to consent to being taken over by a new employer—a federal bureau—by which the physician is not now employed, so how could he strike against it?

* * *

Is the AAPS in opposition to or in competition with the AMA? The AAPS was founded by loyal members of the American Medical Association, and admits in membership only physicians who are members of their county medical societies. Members of county medical societies are automatically members of the AMA so that, in effect, only members of the AMA are members of the AAPS. It is inconceivable that members of the AAPS could compete with or oppose themselves as members of the AMA. Further tangible proof of the intention of the members of the AAPS to supplement and not to compete with the work of the AMA was given at the Annual Meeting of the AAPS, when it withdrew action upon certain of its objectives in legislation, public relations and medical economics that had recently been added to the program of the AMA.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

New Drugs Hold Powerful Promise

Conference Calls Them Venereal "Sure Cure"

Frank Carey, Associated Press Science Writer, in San Francisco *Chronicle*

What has been called a "sure cure" for all cases of gonorrhea is believed to be in hand, along with an apparently positive and quick cure for 90 per cent of early syphilis cases, Dr. J. R. Heller, Jr. of the U. S. Public Health Service, said recently.

This, he said, is the conclusion of an international conference on venereal disease "whose closing yesterday marked the opening of the final chapter in the eradication of syphilis and gonorrhea in this country."

(More than 5,000,000 cases of gonorrhea occur annually in the United States, and 230,000 cases of syphilis.)

Heller, chief of U.S.P.H.S.' Venereal Disease Division, hailed the conference as "historic" in the centuries-old fight against the two diseases.

"For it brought together," he said, "the largest number of venereal disease experts ever assembled at a time when they could give first comprehensive appraisal to recent results obtained with new methods of treatment, including penicillin alone for both diseases and other 'rapid treatment' methods against syphilis.

"The indications from the pooled data are that when penicillin becomes freely available, the private physician will have in his hands a sure cure for gonorrhea.

"And the further evidence is that through the availability of penicillin and other 'rapid treatments' at 63 special centers now in operation, we have the means for the apparent cure of about 90 per cent of early syphilis cases and of rendering the rest incapable of infecting other persons."

And he said these rapid treatments for syphilis are "effective within a few days instead of 18 months as heretofore under older methods." The doctor said strains of both diseases entirely resistant to penicillin might yet appear, but they haven't yet.

Heller declared that while the conference had shown that science now is armed with effective treatment methods, it had spotlighted the need for finding existing cases and eliminating promiscuous sexual relations if the two diseases are finally to be eliminated.

"Up to now," he said, "the medical profession in general and the public health service in particular have taken the view that venereal disease is primarily a medical affair and that we should not go into the moral aspects of it, at least in our rôle as doctors.

"But it is the stand of this conference that we must recognize promiscuity as a major factor in the spread of the diseases and we as doctors must take the initiative to keep that factor ever before the character-building agencies, such as the home, the church and the school."

The conference, attended by representatives of various natoins, also emphasized the necessity for closer coordination on the international front of venereal disease —particularly with reference to the protection of merchant seamen and other nationals traveling from country to country.—San Francisco *Chronicle*.

The Treatment and Prevention of Diphtheria

According to George M. Uhl, M.D., Health Officer, the incidence of diphtheria in the City of Los Angeles continues at a high level. During the entire year of 1944, there were 261 cases and 21 deaths.

Over half of the deaths from diphtheria occur in preschool age children. Diphtheria may be prevented in children by the administration of diphtheria toxoid. When the disease occurs, death may be prevented by early diagnosis and early institution of antitoxin therapy. The Los Angeles City Health Department further believes that all cases of diphtheria should be hospitalized.

During the past year, the Los Angeles City Health Department has doubled its number of immunizations against diphtheria, and at the present time is conducting a widespread campaign to publicize the importance of immunization. The Health Department calls upon all physicians in Los Angeles to coöperate in an effort to stamp out this dread disease. Physicians are asked to:

1. Make positive effort to immunize all children in their practice under 10 years of age;

2. Do not temporize with the diagnosis of diphtheria. Be sure! If diphtheria is suspected, either (a) send the patient immediately to the Los Angeles County Hospital, Communicable Disease Unit, for further study or (b) give adequate antitoxin immediately. Don't wait for culture report. It may be too late.

Tuberculosis Reporting

The Director of the California Department of Public Health, Dr. Wilton L. Halverson, has sent the letter which follows:

(COPY)

George H. Kress, M.D.,
Editor, CALIFORNIA AND WESTERN MEDICINE.
Dear Doctor Kress:

Attached is a statement regarding the reporting of communicable disease, especially tuberculosis, which you may wish to run in the *Journal*. Reporting of various communicable diseases in California, as you well know, is gradually growing better, but at best tuberculosis is not completely reported in any section of the State.

To eradicate a disease such as tuberculosis, it is essential to know the current incidence of the disease and to know what happened in the past. Additional Federal funds are being made available for the purpose of the "eradication" of tuberculosis and it should be possible to improve our program materially.

Very sincerely yours,
WILTON L. HALVERSON, M.D.,
Director of Public Health,
State of California.

TUBERCULOSIS REPORTING

During the present time when the busy practitioner is working under high pressure there may be a tendency to neglect the routine of reporting of communicable diseases. It is because of this fact that I write this report —making a plea for the continued coöperation of all physicians in reporting such diseases.

One of the first essentials in preventing the spread of communicable diseases is the notification of cases. It is an established public health procedure. Reporting in California on the whole is excellent, but I should like to point out that it is by no means perfect.

If we inspect a compilation of data taken from tuberculosis cases reported among civilians since January 1, 1941—we find that of the 22,806 cases reported, 2,141 cases were reported only at death. That is, 9.4 per cent died of tuberculosis without having ever been officially reported as tuberculosis cases during their illness. By years these data are as follows:

1941—684 cases or 9.4 per cent reported only after death.
1942—692 cases or 9.1 per cent reported only after death.
1943—765 cases or 9.7 per cent reported only after death.

In localities where public health facilities are at a minimum, the data are even less favorable. Taking the period January-September, 1943, we analyzed the tuberculosis deaths from 30 such counties and found:

6 counties with no deaths.
24 counties with 283 deaths.

Of the 283 deaths, 94 or 33.2 per cent had never been reported as cases before death.

Considering the 22,806 cases of tuberculosis from the standpoint of status of infection at the time of first being reported, we find that:

20.2 per cent were classified as minimal.
34.0 per cent were classified as mod. advanced.
43.3 per cent were classified as far advanced.
2.5 per cent were classified as other stages.

Apparently at least one-half of all utberculosis cases have reached the stage where they are a great menace to their families and the general public before being recognized or reported as cases. It is evident that they have been found too late to prevent them acting as foci of infection.

When we consider the reporting agency we find that 6,894 cases or 30.2 per cent of all reported cases were submitted by private physicians and private hospitals, while 15,912 or 69.8 per cent of all reports were from public sources—such as clinics, county hospitals, Coroners, Federal and State agencies.

Inasmuch as tuberculosis is a disease seriously affecting the economic status of the individual, it would be expected that private physicians would be more likely to see the early type of its lesions and therefore, report more such lesions than public institutions. However, the reporting is as follows:

	Reported by private agencies		*Reported by public agencies*	
Stage	*No. cases*	*%*	*No. cases*	*%*
Minimal	955	13.8	2,876	18.1
Mod. Adv.	2,262	32.8	4,191	26.3
Far Adv.	2,138	31.0	6,088	38.3
Other Stages ..	121	1.8	346	2.2
Not stated	1,418	20.6	2,411	15.1
TOTAL ..	6,894	100.	15,912	100.

Thus, of the 6,894 cases reported by the physicians and private hospitals, only 955 or 13.8 per cent were minimal. On the other hand, of the total minimal cases (3,831) reported by all agencies, the 955 reported by these private agencies represented ¼ of the group.

	Reported by private agencies		*Total cases reported*	
Stage	*No. cases*	*%*	*No. cases*	*%*
Minimal	955	24.9	3,381	100
Mod. Adv.	2,262	35.0	6,453	100
Far Adv.	2,138	26.0	8,226	100
Other Stages ..	121	25.9	467	100
Not stated	1,418	37.0	3,829	100
	6,894		22,806	

Regardless of the source of reporting it is obvious that if we expect to lower the tuberculosis rate appreciably, more emphasis must be placed on early recognition of the disease before the case has had a chance to become an active focus of infection to others.

There are nationally accepted standards against which we can measure the completeness of reporting. One of these is the ratio of new cases reported, to the annual average of deaths over a 5-year period. In tuberculosis, a good ratio is 3 to 4 new cases to one death.

1941 — Ratio = 1.83
1942 — Ratio = 1.97
1943 — Ratio = 2.06

Any conclusions made on the behavior of tuberculosis in California over a period of years will be only as accurate as the records received. If more reports are submitted at the time of the initial diagnosis we will then know whether early diagnosis and tuberculosis case work are being properly evaluated.

The same may be said of venereal diseases and the other reportable diseases—our knowledge of the effectiveness of present day control methods can only be determined when case reporting is adequate.

The California Department of Public Health aims to serve as a clearing house on communicable disease data. Requests from physicians for compilations always receive prompt attention.

668 Phelan Building, San Francisco 2.

Rabies in California

The present rabies situation in California calls for extreme alertness on the part of all local health officers. The death, about the middle of September, of a three and a half year old child, who had been bitten by a rabid dog in Albany, in Alameda County, focuses the attention of all health officers upon the need for the adoption of preventive measures and for the exercise of rigid control over dogs and cats in those communities where rabies is known to be present. During the past year the disease has been found in Kern, Imperial, Tulare, Kings, Fresno, Los Angeles, Monterey, Napa, Contra Costa, Riverside, Sacramento, San Bernardino, San Diego, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus, and Alameda counties.

The latest area to be visited by this disastrous disease in dogs is the east shore of San Francisco Bay, particularly in Berkeley, Albany, El Cerrito, Richmond and Crockett.

The first recorded presence of rabies in California was in Pasadena in 1899.

Since 1899, no less than 19,926 cases of animal rabies have been recorded in the State. By years, they are as follows:

Year	*Number*	*Year*	*Number*
1899	No record	1927	376
1909	No record	1928	791
1910	18	1929	787
1911	66	1930	929
1912	244	1931	800
1913	327	1932	508
1914	212	1933	681
1915	63	1934	1,035
1916	196	1935	926
1917	41	1936	1,052
1918	29	1937	2,172
1919	73	1938	1,730
1920	176	1939	899
1921	124	1940	396
1922	566	1941	440
1923	1,092	1942	531
1924	500	1943	740
1925	353	1944 (to September 1)	678
1926	375		

During the same period 100 human deaths from rabies have occurred in the State.

Measles and smallpox are said to have made their first appearance in 621.

The first description of elephantiasis is credited to Straton of Lampsacoos (280 B. C.).

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

See editorial comment, in this issue.

American Medical Association. The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10.15 a. m., under the title, "Your Doctor and You."

In April, KFAC will present these broadcasts on the following Saturdays: April 7, 14, 21, and 28.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors Look Ahead" by the American Medical Association is on the air each Saturday at 1:00 p.m., Pacific War Time. N.B.C. Network.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Books, Books, Books:* C. C. Thomas of Springfield, Ill., comes to town again with M. G. Sevag's *Immune-Catalysis* (preface by S. Mudd, 1945, $4), and S. E. Gould's *Trichinosis* (1945, $5). Commonwealth Fund (41 E. 57th, N. Y. 22), announces publication of I. Galdston's Committee on Medicine and the Changing Order of N. Y. Academy of Medicine: B. J. Stern's *American Medical Practice in Perspectives of a Century*, and *Medicine in Industry;* E. H. Corwin's *The American Hospital;* F. D. Mott's *Rural Medicine;* N. Sinai's *Varieties of American Insurance and Prepayment Plans for Medical Care;* R. B. Allen's *Medical Education;* H. S. Mustard's *The Development of Community, State and National Public Health Services;* E. J. Stieglitz's *Preventive Medicine;* A. Gelinas's *Nursing;* R. H. Shryock's *Medical Research,* and M. W. Carr's *Dentistry.* Remember the publications of the Committee on the Costs of Medical Care, which University of Chicago Press published between 1928 and 1932? Excellent is H. B. Richardson's *Patients Have Families* (Commonwealth Fund, N. Y., 1945, $3). Also excellent is K. D. Blackfan and L. K. Diamond's *Atlas of the Blood in Children* (Commonwealth Fund, N. Y., 1945, $12). D. I. Abramson offers *Vascular Responses in the Extremities of Man in Health and Disease* (University Chicago Press, 1945, $5). Much on U.S.S.R. medicine is included in *Science in Soviet Russia* (Cattell, Lancaster, Pa., 1945, $1.50). H. C. Solomon edits *Manual of Military Neuro-psychiatry* (Saunders, Philadelphia, 1945, $6). G. J. Heuer reviews 10 years experience on the *Treatment of Peptic Ulcer* (Lippincott, Philadelphia, 1944, $3). And for escape there's *The Thurber Carnival* (Harper's, N. Y., 1945, $2.75), and J. Barzun's *Teacher in America* (Little Brown, N. Y., 1945, $3).

2. *Semiotics:* W. D. Collings recommends F. C. Redlich's investigation into the use of medical terms (The Patient's Language, *Yale J. Biol. Med.*, 17:427, 1945). Also note C. D. King's study of the meaning of normal (*Ibid.*, p. 493) University California Press will publish A. B. Johnson's *Philosophy of Human Knowledge, or a Treatise on Language* (N. Y., 1928).

3. *Infections:* M. Mitman well discusses aerial infections, condemning hospital blankets and overcrowded busses and faintly praising ultraviolet radiation (*Brit. Med. J.*, 1:72, Jan. 20, 1945). M. G. Sevag studies mechanism of resistance of organisms to sulfonamides, and inhibitory action of zephiran (*J. Bact.*, 58:615-638; 677, 1944). W. Heine commends serodiagnosis of Tb (*Zentr. Bakt. Infekt.*, 151:174, 1944) W. E. Coutts offers evidence indicating respiratory infection with lymphogranuloma virus (*Rev. Chilena Hyg. Prev. Med.*, 6:161, 1944). National Research Council issues mimeoed survey of antimalarial drugs by O. Temkin and E. M. Ramsey, deserving book printing (Washington, 1944, 237 references).

4. *Histamine:* C. V. Anrep & Co., of Cairo, discuss excretion of free and conjugated histamine in urine (*J. Physiol.*, 103:155, 1944). F. Alexander describes metabolism of histamine noting high skin content and kidney excretion (*Quart. J. Exp. Physiol.*, 33:71, 1944).

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

M. Laskowski and J. M. Lemley study histaminase, obtaining protective but toxic product (*Arch. Biochem.*, 6:105-120, 1945).

5. *And Then:* J. B. McClinton homilizes on the Doctor's Own Ethics (*Canad. Med. Asso. J.*, 52:199, 1945). D. A. Roman-Vega and J. Adriani (*Anesth. Analyg.*, 23:248, 1944), confirm D. Jackson's report on sympathomimetic action of 2-methyl-amino-heptane (*J. Lab. Clin. Med.*, 29:150, 1944). I. Gersh and M. A. Still note significance of blood vessels in fat tissue in gas exchange (*J. Exp. Med.*, 81:219, 1945). A. A. P. Leao and R. S. Morison note depression of electrical activity of cortex following tetanic stimulation, similar to epiletiform discharges (*J. Neurophysiol.*, 8:33, 1945). L. Colbrook & Co. report on burns and scalds (*Med. Res. Coun. Spec. Rep.*, 249, London, 1944). J. H. Annegers & Co. recommend dehydrocholic acid to prevent hepatotoxic action of arsenicals (*Arch. Derm. Syph.*, 51:112, 1945). A. S. Wiener & Co. show relation of Hr factor to Rh blood types (*J. Exp. Med.*, 81:63, 1945). W. M. Parkins & Co. report neosynephrin in gelatin solutions with penicillin prolongs blood levels for several hours after IM injection (*Science*, 101:203, February 23, 1945). A. Marshak and A. C. Walker find liver chromatin (A. Claude and J. S. Potter, *J. Exp. Med.*, 77:345, 1943), stimulates mitosis and granulation in wounds, and that phosphorus building in nucleus offers way to control gene mutations (*Science*, 101, 94, January 26, 1945). J. Barcroft & Co. suggest that Wharton's jelly acts as a conducting pathway from placenta to fetus (*Nature*, 154:667, November 25, 1944). E. Slater indicates inheritable tendency of families to produce children predominantly in one sex (*Ann. Eugenics*, 12:121, 1944).

Mayo Memorial.—Many of the persons, both physicians and laymen, who have either admired the Mayo brothers or benefited in some way by their contribution to medical science will be pleased to know that a memorial is to be built in their honor.

Doctor Toland has announced that people living in California will be able to contribute to this proposed memorial which is to be erected on the campus of the University of Minnesota Medical School in Minneapolis. Serving with Doctor Toland is a Committee which will carry on the appeal in California: Dr. William H. Goeckerman, Los Angeles, vice chairman; Albert J. Scholl, Los Angeles, secretary and treasurer; Dr. Frederick A. Olson, Los Angeles; Dr. Harold L. Thompson, Los Angeles; Dr. Dwight L. Wilbur, San Francisco; Dr. Whitfield Crane, Oakland; Dr. Samuel Robinson, Santa Barbara; Dr. John H. Shepard, San Jose; Dr. Hermon C. Bumpus, Jr., Pasadena, and Dr. Leslie H. Redelings, San Diego.

Work to be done through the proposed memorial research center may well affect the practice of medicine and the health of the general public everywhere, Doctor Toland said.

Dr. Ray Lyman Wilbur, chancellor of Stanford University, is one of the national sponsors of the Mayo Memorial.

"The Mayo Clinic has been an important factor in American medicine throughout all of my active professional life," Dr. Wilbur said. "I saw it pioneer in group medicine and grow into one of the great world centers of medical care and medical research, as well as of advanced medical education. Thousands of physicians and scientists from all over the world have been a part of this unique American institution.

"Doctor Will Mayo talked with me at the time he and his brother were thinking of linking their work with that of the University of Minnesota. They believe in keeping medicine and the university in close association.

"It is certainly appropriate to build a memorial on the campus of the University of Minnesota as a tribute to what Will and Charlie Mayo have done in medical education and in the advancement of all medical knowledge. The great work which they pioneered should continue to be a living vital force for human welfare."

The proposed Mayo Memorial will be a twelve-story building, to be constructed at an approximate cost of $2,000,000. It is expected that the state legislature of Minnesota will appropriate $1,000,000 toward the cost, contingent upon the raising of the remaining million from private gifts. Bills providing for such an appropriation are now before the Senate and the House. The appeal for funds will be carried on nationally to give the friends of the Mayos all over the country a chance to contribute.

Please contribute as much as possible, and mail your check to Doctor A. J. Scholl, secretary-treasurer, 1930 Wilshire Boulevard, Los Angeles 5, California. Your donation will be deductible from your income tax. Request for copy of the brochure may also be sent to the above address.

How Many Jobs for Californians?—There will be between 700,000 and 1,000,000 more job seekers one year after general demobilization than there were in 1940.

These and other facts and predictions are contained in a new pamphlet, "How Many Jobs for Californians?" now ready for distribution, the California State Reconstruction and Re-employment Commission, Sacramento, announced recently.

The pamphlet is one of a series designed to keep Californians aware of the postwar problems they face and how best the State may meet the after-the-war adjustment.

Victims of Malaria Show False Symptoms of Syphilis.—Malaria victims often show false symptoms of syphilis when given venereal disease tests, three Army officers recently reported.

The report urged caution in the diagnosis of syphilis in malaria patients. Because many reactions to test may falsely indicate such patients are venerally infected, the wrong diagnosis may produce a greater disaster in mental reactions of patients, than the disease itself.

The doctors said 100 malaria patients, who had no history of syphilis, were given blood and spinal fluid tests within 48 hours after they were admitted for treatment.

Asserting that the factors responsible for the false symptoms appear in the blood but not in the spinal fluid, the doctors warned physicians against diagnosing syphilis from only one of the tests.

They recommended that a month should elapse after an acute malaria attack before blood is taken for other tests.

Social Aspects of Social Security.—In an editorial analysis of a significant study of social security by a group of life insurance actuaries and executives, printed in *New York Medicine*, Vol. 1, No. 6, appeared an article from which the following excerpts have been taken:

Again it is pointed out that "before adopting a social security plan, with its direct bearing on the lives of millions of individuals, as well as on the national economy, there should be the most careful analysis and

forecasting of its probable over-all results. In so broad a field initial measures set patterns and precedents, not easily changed, even though subsequently proven unwise by the test of experience." As to the tests by which the soundness of a particular proposal is to be measured, some of the principal criteria mentioned are:

The maintenance of the incentive to work and to produce;

The proper decentralization of control in order to make the plan more responsive to the needs of the individual;

The need of preventing the overwhelming accretion of political power;

The need of avoiding the crippling of individual initiative;

The maintenance of individual responsibility on the part of every citizen toward his own future and that of his family; and

The desirability of encouraging rather than stifling voluntary and community action in the social field. . . .

It is further pointed out that "if, under any medical or hospital service plan, the government undertakes to arrange for the actual furnishing of services, an element of outside control is introduced over the kind and quality of service and over the personnel and institutions rendering it, as well as over their income and course of funds. . . . Such a plan could bring about an actual deterioration in the quality of medical attention, with scant hope of improvement through a reversion to voluntary action owing to the practical difficulties of retracing the steps that led to government control."

General Conclusions

The study concludes that in a democracy, the voluntary approach is greatly to be preferred to government compulsion and every effort should be made to utilize voluntary coöperative enterprise, "before resorting to a compulsory government program."

If it subsequently appears desirable to experiment with government plans, this should be done at the local or state level rather than at the federal level, the report asserts. . . .

Finally, this study—somewhat uniquely—characterizes the coöperation of the medical profession as "essential in plans for the better distribution of medical care."

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Forgotten Children

The condition of the 10,000 spastic children in California makes action imperative on bills pending in the Legislature to provide attention for this pathetic group. The problem is one much neglected and is known to the general public only when some related circumstances bring individual cases to notice. The little victims of chronic spasm afflictions usually are kept from public view by sensitive families. This, and the general misapprehension that the condition is beyond remedy, helps account for the lack of public awareness. We urge the pending bills to the consideration of the Legislature as something that should have priority in the health and welfare program. —San Francisco *Chronicle,* March 16.

60,000,000 Jobs?

Perhaps no more silly or demagogical slogan has ever been set up in American political history than that of "60,000,000 jobs." The old "full dinner pail" and the "two cars for every garage" made some degree of sense, for at least they were based upon a goal broad enough and general enough to be no more than symbols of the prosperity toward which this country or any other country is perpetually working. But "60,000,000 jobs" doesn't make any sense. . . .

Let's examine the figures regarding employment as nearly as we can judge them. And I think it reasonable to say that any one who reads the daily newspapers intelligently will come just about as near to the truth as the myriads of adding machines in Washington. In the first place there are in this country approximately 78,000,000 people between the age of 18 and the retirement age of 65. Of these approximately 40,000,000 or more are women. How many of these women could or even want to work regularly? There are approximately 35,000,000 families and households which need women to run and manage them. To say one-half of the women need or want jobs would be wildly overgenerous. There are also about 13,000,000 farmers of whom the majority are proprietors. We have a normal migratory population of 3,000,000 or 4,000,000 which prefers to be migratory, picking up work here and there. And we have a population of at least 5,000,000 to 6,000,000 which are so undernourished, so inferior physically that jobs and work play but a small part in their lives. These we shall have with us until something is done for their background and diet. And we have a few millions of people who just don't like work and probably never will, who would rather cadge a living or work a racket like WPA. Whether it is un-American or not, it is also necessary to record that we have at least a million prostitutes, race track touts, gamblers and criminals who want no honest job offered them. In normal times we have about one million young people in colleges and universities. We have an annual birth rate of nearly three million babies which requires that approximately a corresponding number of women must take time out during the year.

Idea Absurd

Add to the above figures countless other elements of the population who do not need or want jobs or are incapable of doing any work, and you begin to get an idea of the absurdity of the 60,000,000 job slogan. If, tomorrow morning, 60,000,000 jobs were offered American people, there would not be enough men and women to fill them. I do imply that this would not be an admirable and desirous situation. I merely suggest that 60,000,000 jobs are a lot more than we could need or fill. . . .— Louis Bromfield in San Francisco *Examiner,* March 18.

Tuberculosis in San Francisco Chinatown Still Major Problem

Tuberculosis in San Francisco's Chinese population remains the city's major public health problem, according to statistics compiled by the Department of Health.

The estimated Chinese population for 1944 was 18,000. Taking 100,000 as the measuring unit, the Department of Health estimated the pulmonary tuberculosis rate for this figure in 1944 among Chinese at 227.8.

The death rate among pulmonary tuberculosis sufferers for the city as a whole was 47.6 per cent in 1944.

The general death rate picture among the Chinese increased from 12.9 in 1943 to 13.6 in 1944.

Statistics for all causes of death "indicate that, other than tuberculosis, the health record of the Chinese compares favorably with the city as a whole," the report states.—San Francisco *Chronicle,* March 18.

Kenny Probe by Congress Sought

Washington, March 21.—(INS)—Representative O'Toole, Democrat of New York, announced today that he will ask the House to investigate "difficulties" experienced by Sister Elizabeth Kenny, famed for her infantile paralysis treatment, since she came to the United States from Australia.

The Congressman said he would introduce a resolution tomorrow calling for appointment of a five man committee to conduct the inquiry. Its purpose, among other things, will be to determine whether there has been any "organized opposition" to acceptance of the Kenny treatment, he said.—San Francisco *Examiner,* March 22.

Federal Hospital Construction Program

Attention is invited to an analysis of a hospital construction bill that appeared in *J.A.M.A.* for January 20, on page 162. Reprints of that analysis will be available shortly and may be obtained on request. This bill, S. 191, through an appropriation of $110,000,000, seeks to give legislative effect to the proposal that Surgeon General Parran made before the Pepper Subcommittee on Wartime Health and Education, namely, that the Federal Government should initiate a broad program for the construction of hospitals and related facilities.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Malpractice: Liability Based on Failure to Take X-ray in Treatment of Broken Bone

In the case of *Lashley vs. Koerber*, 26 A.C. 1, on February 20, 1945, the Supreme Court reversed a decision of the trial court granting the defendant physician and surgeon's motion for a non-suit and entering judgment for the defendant. It was held by the Supreme Court that the plaintiff had presented sufficient evidence of malpractice to justify sending the case to the jury.

The action was brought because of the alleged failure of plaintiff's broken finger to heal properly and in large part, the action was based on the failure of the defendant physician and surgeon to have an x-ray taken of the finger at the time of the setting or shortly thereafter. The general proposition of law applied in malpractice actions is that a physician in treating a patient is only required to have and exercise the degree of learning and skill ordinarily possessed by other physicians of good standing practicing in the same community. The necessity of using x-ray in fracture cases would therefore depend upon whether this general standard of care required its use; that is, upon whether an ordinarily skilled physician practicing in the community would use an x-ray machine in the reduction and treatment of a fractured finger.

Ordinarily the standard of care required in a particular case, and the defendant physician and surgeon's departure from that standard of care must be established by plaintiff through testimony by expert witnesses. In *Lashley vs. Koerber*, the only witnesses at the trial were plaintiff, her husband, and the defendant. No expert witnesses were called by plaintiff. At the conclusion of plaintiff's case, the trial court granted a non-suit, holding as a matter of law that the record was totally devoid of any evidence upon which a judgment for plaintiff might be based. In reversing this decision, the Supreme Court stated that expert testimony by other physicians was not required in every malpractice case, and that "the expert testimony which establishes plaintiff's prima facie case in a malpractice action may be that of defendant." Where there is some evidence that the defendant even in a statement outside of court has admitted negligence or lack of skill ordinarily required for the performance of the work undertaken, plaintiff has sufficiently established her case and justified its submission to the jury for decision.

In the *Lashley* case, plaintiff testified that she had caught and crushed her finger in a folding bed; that she consulted defendant and several days later defendant splinted the finger without taking an x-ray, even though plaintiff had asked him if one should not be taken. Sometime later after the finger had failed to heal properly, plaintiff testified that defendant told her to have an x-ray taken, stating that he "should have taken it in the beginning" and that "it is all my own fault."

On cross-examinatoin, defendant had admitted that if he had had an x-ray picture taken in the early stages of the fracture, he "would have been able to see that the fragment of bone was uniting or out of position" and that it would have made him "suspicious that something was keeping it from uniting properly."

On the basis of these admissions by defendant, the Supreme Court concluded:

"In the present case we are satisfied that a jury, considering the background of all the other evidence, could reasonably conclude that the admissions of defendant physician imported that he had not exercised that reasonable degree of skill and learning and care ordinarily exercised by other doctors of good standing practicing in the community and that as a proximate result of such negligence plaintiff suffered damage. To phrase it differently, in the light of the seeming conflicts in defendant's testimony and all the other circumstances of the case, his admissions that he 'should' have had an x-ray taken 'in the beginning' and that he was at 'fault' in that regard constitute evidence of a character competent to require that the issue of defendant's negligence be decided as one of fact rather than of law.

"For the reasons above stated the judgment is reversed."

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

LETTERS

Concerning Courtesies Extended at C.M.A. Special Session:

(COPY)

SOUTHERN CALIFORNIA STATE DENTAL ASSOCIATION
Los Angeles 14, California

George H. Kress, M.D.,
Secretary, California Medical Association.

Dear Doctor Kress:

May we express our appreciation for the many courtesies which have been extended representatives of the dental profession in their recent conferences with your group.

The interest which has been taken in the dental aspects of health and in dentistry as an important part of the general health service is gratifying and we trust that you will always feel free to call upon the members of our profession to assist in rendering that technical information for which they are best qualified.

Very cordially yours,
(Signed) HARRY H. BLEECKER, D.D.S.,
President, Southern California State Dental Association.
(Signed) ERNEST F. SODERSTROM, D.D.S.,
President, California State Dental Association.

Army Statement Concerning Atabrine

The Army Medical Department recently came out flatly, and rated atabrine, the war-developed substitute for quinine, as "even better" than quinine in the suppression and treatment of malaria.

It was the Army's first unqualified statement with respect to the effectiveness of the synthetic drug.

The medical department rated atabrine in the No. 1 spot for these reasons:

1—In a "high percentage of cases," Army doctors said, atabrine will actually cure cases of falciparum malaria, the type which causes most deaths. (A recent report by the National Research Council declared evidence of a curative effect of quinine on this type of malaria is "not conclusive.")

2—In the treatment of the more common type of malaria—benign tertian malaria, which rarely causes death —the Army says atabrine "is just as effective and less toxic than quinine."

At the same time, Maj. O. R. McCoy, chief of the tropical disease control division of the Surgeon General's office, declared there is little danger of any serious epidemic of malaria in the continental United States traceable to soldiers returned from malarious battlefronts.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 4, April, 1920

EXCERPTS FROM EDITORIAL NOTES

Important Announcement by the Program Committee.—The attention of the members of the State Society is called to the article appearing in another column, entitled "Rules Governing Reading of Papers and Discussions at State Society Meeting." A few words of explanation regarding these rules might not be amiss. Because man is not born perfect, does not attain perfection nor has, so far as we have been able to observe, ever had perfection thrust upon him and because of variance of opinion between different individuals as to relative values and in respect to other matters, it was learned very early that certain rules and regulations are necessary in order that the business of society, and of societies, might be carried on expeditiously and harmoniously. The object of the authors of such rules and regulations, in a democracy, is to so frame the laws as to promote the greatest liberty and the greatest good to the greatest number. This also is the object of the members of the Program Committee. The rules and regulations are the result of the teachings of past experience. Three of the six rules for authors and each of the three rules for those taking part in discussions have to do with time limits. . . .

For the benefit of any would-be recalcitrant who may expect a modification of the rules for his benefit, the reader is respectfully referred to the sixth chapter of the book of Daniel and the twelfth verse, particularly the last line of this verse which refers to the laws of the Medes and Persians. For the benefit of any who may not possess the aforenamed volume it may be added that the same may be found in any public library and in most homes.

Doctor C. A. L. Reed Lauds Public Health League.—Doctor Charles A. L. Reed of Cincinnati, past president of the American Medical Association, Professor Emeritus of the Medical Faculty of the University of Cincinnati and prominent promoter of public health work, in an address before the Alameda County Health Center, devoted a goodly part of his address to analyzing and commending the aims and achievements of the League for the Conservation of Public Health. Dr. Reed said he had heard a great deal about this unique California organization before his arrival, but from the time he reached Los Angeles and San Diego, until the evening of his address, he heard from so many reliable sources what the League had done, was doing, and going to do, that he was both delighted and disappointed.

We quote from the Oakland *Tribune*, Dr. Reed's tribute delivered during his address, "The Public, the Medical Profession, and the New Era":

"In preaching this gospel in California I experience both disappointment and satisfaction; disappointment in finding myself engaged in the always unwelcome task of merely carrying coals to Newcastle; satisfaction in discovering that the principles for which I am contending have already here commanded recognition and are being

(Continued in Front Advertising Section, on Page 20)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M.D.
Secretary-Treasurer

Board Proceedings

At the recent meeting of the Board of Medical Examiners held in Los Angeles, 153 applicants wrote the examination for a physician's and surgeon's certificate. Most of the applicants were recent graduates and many took the examination just prior to entering one of the branches of military service.

After hearings before the Board, the following disciplinary actions were taken:

Boyajian B. Armen, M.D., charged with violation of his probation, was on March 2, 1945, found guilty as charged and his California certificate to practice as a physician and surgeon was revoked;

Herman B. Misch, M.D., charged with illegal operation, was on March 2, 1945, found guilty as charged and his license to practice as a physician and surgeon in this State, was revoked;

John Robert Brown, M.D., charged with narcotic law violation, was on Feb. 28, 1945, found guilty as charged and placed on five years probation, without narcotic privileges or possession.

Several cases were continued to subsequent meetings.

The Board held an oral examination, as advertised, on Saturday, March 3rd, in the State Building, Los Angeles, at which 54 candidates presented themselves for examination.

As previously stated in this column, an additional written examination has been scheduled to be held at Native Sons Hall, 414 Mason Street, San Francisco, May 21, 22 and 23, 1945.

An oral examination for reciprocity candidates will be held at the Board offices, 515 Van Ness Avenue, Room 214, San Francisco, May 20, 1945.

News

An Assembly Bill of considerable interest is AB-1697 (Massion) which would require the licensing of dispensers of Chinese herbs.

"The sudden rise in the number of Selective Service inductees claiming to be suffering from a kidney disease which would disqualify them from military service was under scrutiny by the Federal Bureau of Investigation and resulted in the arrest of one youth, R. B. Hood, special agent in charge of the Los Angeles office, declared today. Held by the F.B.I. and facing arraignment before United States Commissioner David B. Head is George Clyde Todd, 19, of 421 North Woodruff, Bellflower, who, Hood alleged, falsely claimed that he was suffering from enuresis, when he received his physical examination. Because of the high number of these cases reported to the induction officials recently, Todd was sent to an Army hospital for further observa-

(Continued in Back Advertising Section, on Page 44)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



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Myerson, A.—*Anhedonia*—
Am. J. Psychiat., July, 1922.

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

rates of 298.9 and 284.3 per 100,000, respectively, these being the highest rates which have ever appeared for these causes. The rate in 1917 for influenza was 17.2 and for pneumonia (all forms) was 149.8. In fact the difference (416.2 per 100,000 population) between the 1917 and 1918 rates corresponds with the excess mortality which occurred in the last four months of the year from the influenza pandemic. . . .

Excerpts from County Society Proceedings: The Los Angeles County Medical Association Meeting, February 19, 1920.—"The Medical Profession and the New Era" was the next subject, read by Dr. Chas. A. L. Reed of Cincinnati, former president of the American Medical Association. Dr. Reed advocated the union of doctors so that they may appraise the value of their services to society and exact a fair measure. We have 150,000 members, many nurses, hospitals and sanitaria. The national, state and county societies must effect the maximum organization to investigate compensation for medical services, and this county society should appoint a committee for that purpose. Does the medical group live up to its responsibilities? There are 7,000 hospitals without a pecuniary profit, there are medical schools, thousands of

(Continued on Page 44)

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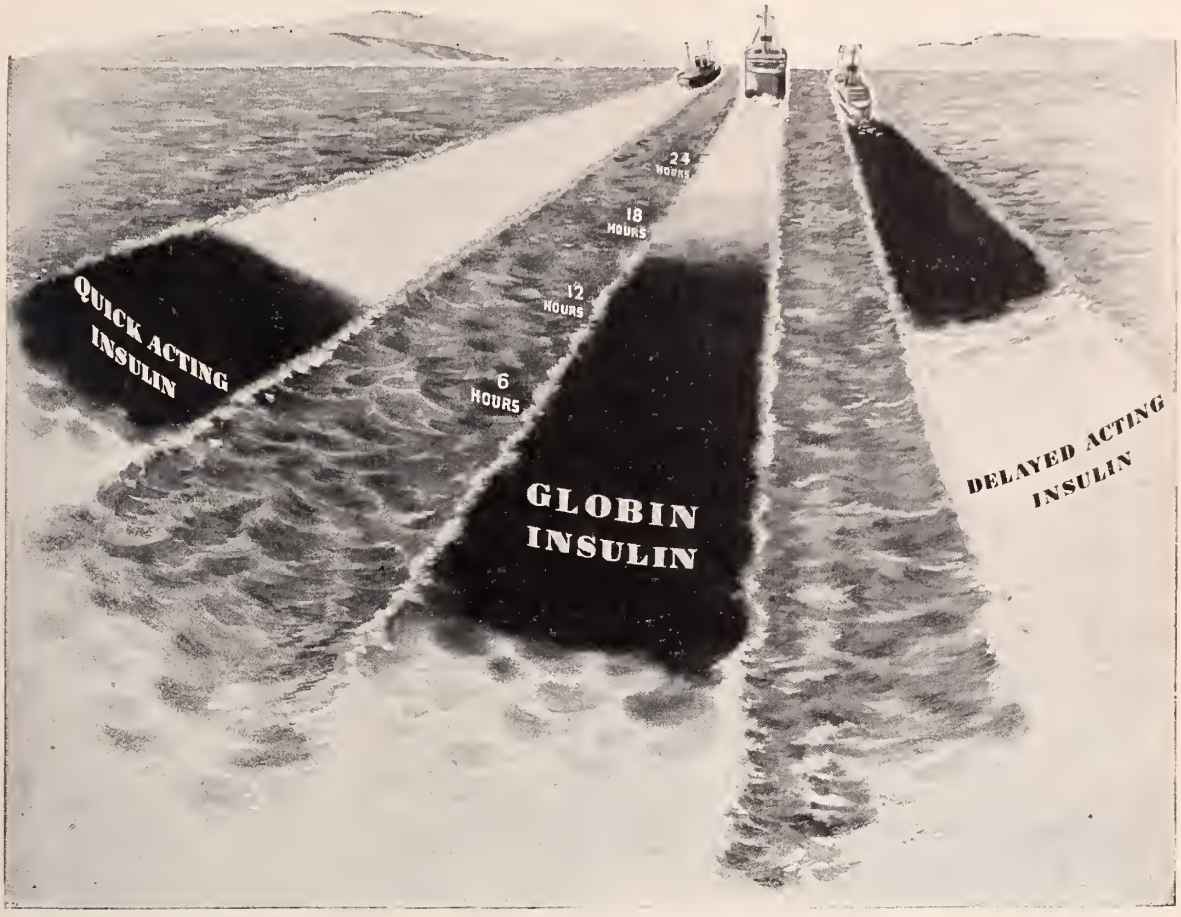
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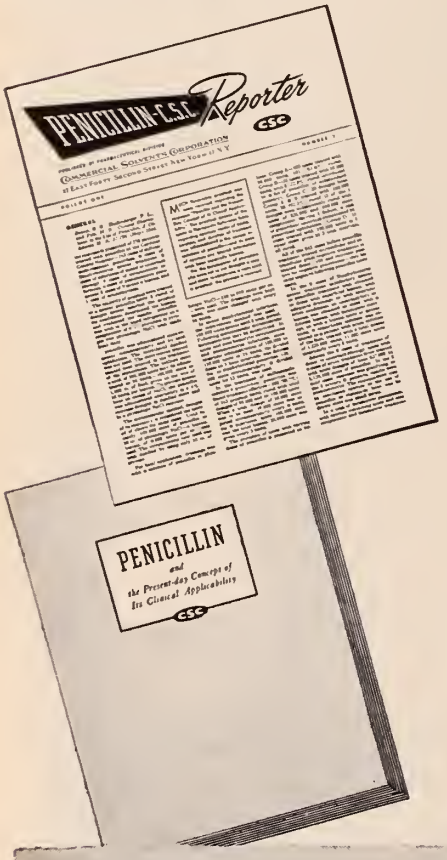
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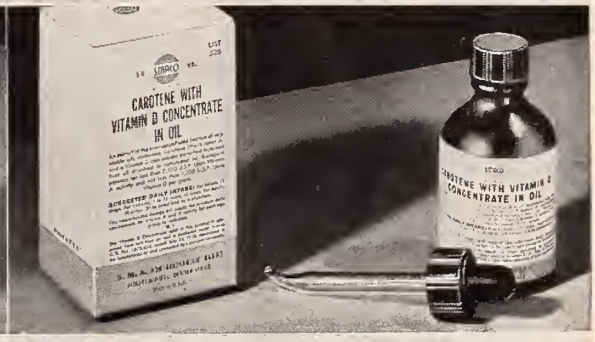
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[1]LUND C. J., and KIMBLE M. S.: Plasma Vitamin A and Carotene of the Newborn Infant, Am. J. Obst. and Gynec. 46: 207-221 (Aug.) 1943.

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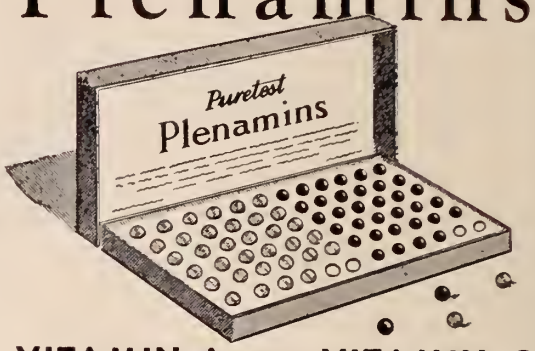
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—New and Nonafficial Remedies: Allergenic Preparatians, Chicago, American Med. Assoc., 1944, p. 56.



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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

poor are visited and the medical profession has served in greater proportion than any other group. Yet the National Health Service is taking orders from the Treasury Department. The Navy Department and the Secretary of the Interior meddle with our work. A single Health Department ought to control. The medical group is subordinated to some overlordship. Medical examiners for insurance companies have made millions for the promoters by working for very little. Shop insurance, the casualty group and such like, dictate the recompense, the Workman's Compensation Act tells what the compensation shall be. The service of medical men is more poorly paid than any other group of society. Dr. Reed referred to the petroleum, the capitalistic and shop groups having each employee examined, all injury given immediate attention, but 300 per cent more is collected than paid the doctor. He urged solidarity, autonomy of the whole medical group. On the other hand, if present conditions continue, they will lower medical efficiency and society will be the greatest sufferer. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 240)

tion, where it was found that he was normal. Approximately 25 other cases are under investigation, Hood declared." (Los Angeles *Herald & Express,* February 17, 1945.)

"To Detective Sgts. Glenn Wasson and A. B. Peterson of the Alhambra Police Department can go credit for recovering $2,000 worth of stolen radium and a stolen car Tuesday night. After the doctor's bag that had contained the valuable element was found in the front yard of an Alhambra home, the two officers made an intensive search of the neighborhood and discovered an automobile owned by Dr. George Steven Sharp of Pasadena that previously had been reported stolen in that city. The precious radium was found in the glove compartment of the car. Evidently the thief had handled it, but did not know its value . . ." (Alhambra *Post-Advocate,* January 31, 1945.)

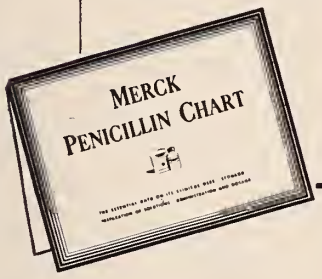
"Two bandits who ransacked the office of Dr. Homer

(Continued on Page 48)

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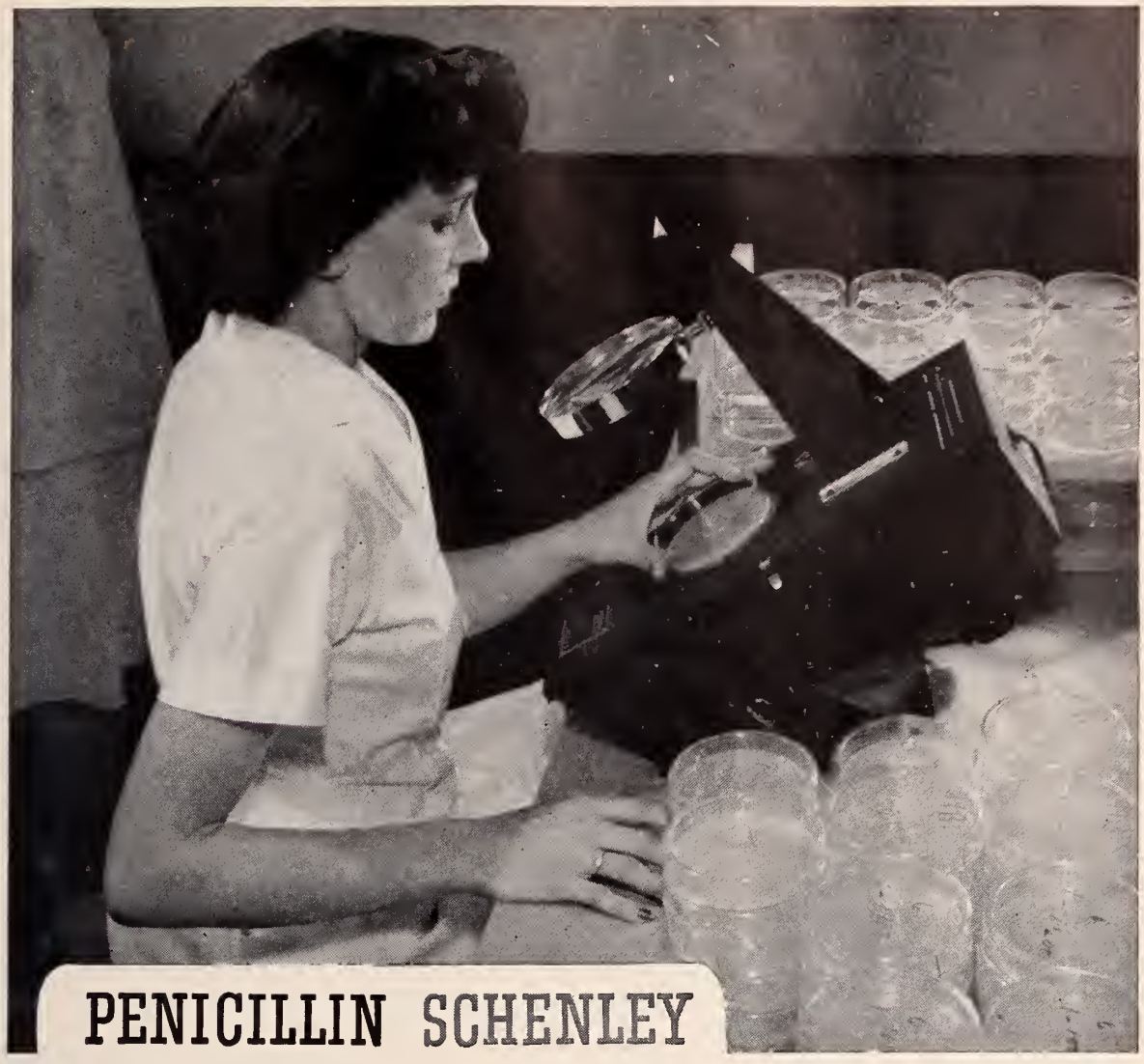
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BOARD OF MEDICAL EXAMINERS

(Continued from Page 44)

Wise at 5566 Santa Monica boulevard in a vain search for narcotics after strong-arming and binding the doctor, were being sought by police today. Though they failed to find any drugs, the pair took $45 cash, the doctor's .32-caliber revolver and his automobile keys." (Los Angeles *Herald & Express*, February 9, 1945.)

"Entering with a pass key, a burglar early today took $1,378 in cash from a desk drawer in the home of Dr. Frank Kliman, 336 North Poinsettia Place, according to police." (Los Angeles *Herald & Express*, February 12, 1945.)

"Maj. Charles M. Wheeler of the Army Sanitary Corps of Brea, Calif., has received the United States of America Typhus Commission Medal for 'exceptionally meritorious service' in the control of typhus. He was one of ten men so honored by the War Department at the direction of President Rooseveit." (Hollywood *Citizen-News*, Feb. 5, 1945.)

"The State Board of Chiropractic Examiners acted illegally in revoking licenses of 22 chiropractors last year, the Superior Court ruled today. The cancellations were ordered by the Board on grounds the licenses had been issued after examinations by single board members in 1942. New members of the board appointed by Governor Warren held that only the entire board could give the tests. However, Judge Malcolm Glenn

(Continued on Page 53)



A STRIP of bandage fluttering from a rifle stock . . . That's the battlefield marker of a wounded soldier . . . that's the Army doctor's *call to action!*

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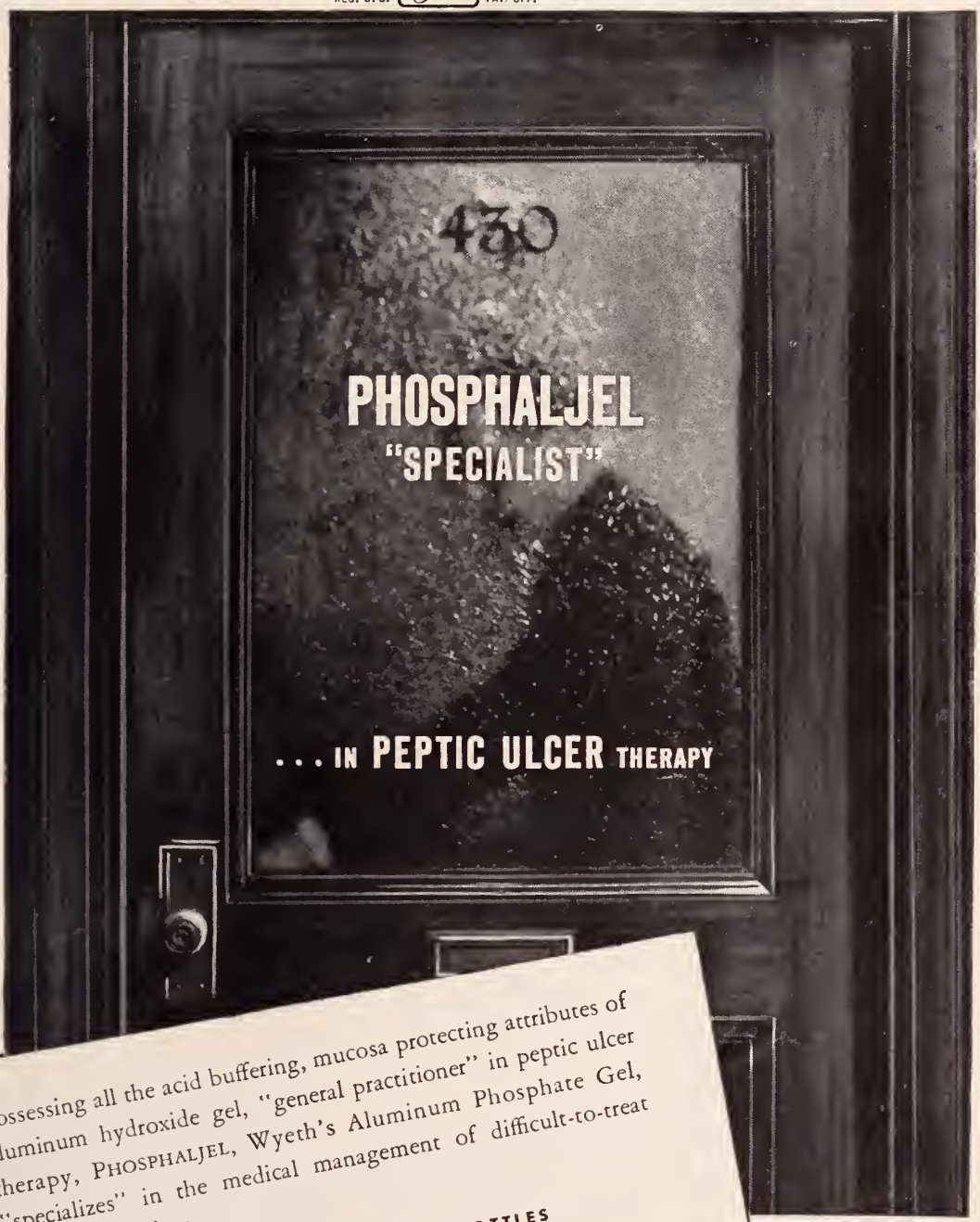
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BOARD OF MEDICAL EXAMINERS

(Continued from Page 48)

held that the chiropractors were entitled to a hearing before the revocations." (San Francisco *News*, March 1, 1945, from Sacramento press dispatch dated March 1, 1945.)

"The tides have turned again for relatives of interned Japanese prisoners as news of the safety of loved ones filtered out of the War Department Adjutant General's office in Washington yesterday. Mrs. Gertrude M. Wilson, 2235 N. Catalina St., expressed her relief and joy when she learned that her son, Maj. Warren A. Wilson, commandant of the war prisoners' hospital at Bilibid Prison Camp, Manila, had been liberated. . . . (Hollywood *Citizen-News*, February 8, 1945.)



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Vice-Chairman—John W. Cline, 490 Post Street, San Francisco, 2.

Secretary-Editor—George H. Kress, 450 Sutter Street, Room 2004, San Francisco, 8.

Executive Secretary — John Hunton, 450 Sutter Street, Room 2004, San Francisco, 8.

General Counsel—Hartley F. Peart, Room 1800, 111 Sutter Street, San Francisco 4.

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In addition to the elected district and at-large Councilors, the Council has as ex-offico members the following general officers, President; President-Elect; Speaker; and the Association Secretary.
Council Officers: Philip K. Gilman, Chairman; George H. Kress, Secretary.

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First District—Imperial, Orange, Riverside, San Bernardino and San Diego Counties, Herbert A. Johnston (1947), 117 N. Claudina Street, Anaheim.

Second District—Los Angeles County, Jay J. Crane (1948), 1921 Wilshire Boulevard, Los Angeles.

Third District—Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties, Harry E. Henderson (1946), 1421 State Street, Santa Barbara.

Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axcel E. Anderson (1947), Medical Group Building, 1759 Fulton Street, Fresno.

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Seventh District—Alameda and Contra Costa Counties, Lloyd E. Kindall (1947), 400 Twenty-ninth Street, Oakland.

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Ninth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1946), Box 539, Vallejo.

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Sidney J. Shipman (1947), 490 Post Street, San Francisco 2.

E. Earl Moody (1947), 829 South Alvarado Street, Los Angeles.

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Edward B. Dewey (1946), Professional Building, 65 North Madison Avenue, Pasadena.

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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
President, Harry J. Templeton, 3115 Webster Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland, 9.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, John H. Alexander, 2nd at Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Joseph W. Boomer, American Trust Building, Richmond.
Secretary, Henry W. McNerney, 2600 McDonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, John E. Young, Rowell Building, Fresno.
Secretary, K. D. Buechauer, 1759 Fulton Street, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Nathan G. Wasserman, 539 G Street, Eureka.
Secretary, Joseph S. Woolford, 539 G Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Marian Hubbell, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, James Lloyd Mason, Bishop.
Secretary, Walter L. Wilson, 108 N. Main, Bishop.
Meeting, *Fourth Wednesday, except December, January, February.*

Kern County Medical Society
President, Sophie L. Goldman, 458 Haberfelde Building, Bakersfield.
Secretary, Juliet Thorner, 109 Eighteenth Street, Bakersfield.
Meeting, *Third Thursday, 7:30 p.m., Bakersfield Inn, except June, July, August.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
President, J. Jay Crane, 418 South Arden Street, Los Angeles.
Secretary, E. T. Remmen, 429 North Orange, Glendale 3.
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Ralph Weseman, Novato.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
Secretary, Dale E. Barber, Fort Bragg.

Merced County Medical Society
President, E. R. Fountain, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Edwin Wiley Reeves, 605 Salinas National Bank Building, Salinas.
Secretary, Dixi M. Bingaman, Bank of America Building, Salinas.
Meeting, First Thursday.

Napa County Medical Society
President, Charles H. Bulson, 1203 Seminary Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Charles E. Irvin, 105 West Sycamore Street, Anaheim.
Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster.
Meeting, *First Tuesday, 8:00 p m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, George A. Foster, Grass Valley.
Secretary, Vernon W. Padgett, Grass Valley.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Omer W. Wheeler, 1939 La Cadena, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Maurice A. Hopkins, Route 7, Box 1246A. Sacramento.
Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, J. J. H. Smith, 137 East H Street, Colton.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, George D. Huff, 806 Medical Building, San Diego 1.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street 9
President, G. Dan Delprat, 384 Post Street, San Francisco 8.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

San Joaquin County Medical Society
President, Yale Brody, Bank of America Building, Stockton 5.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton 2.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Logan Gray, 57 Fourth Avenue, San Mateo.
Secretary, J. Paul Sweeney, P. O. Box 1004, Millbrae.
Meeting, *At call of President.*

Santa Barbara County Medical Society
President, George R. Luton, 103 E. Micheltorena Street, Santa Barbara.
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, Karl F. Pelkan, 903 Medico Building, San Jose.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, L. C. Mosher, Bieber.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, H. Randall Madeley, P. O. Box 539, Vallejo.
Secretary, John W. Green, Box 539, Vallejo, California.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William N. Makaroff, Guerneville.
Secretary, Robert S. Quinn, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, J. H. Czatt, 810 Fourteenth Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p.m., Hotel Hughson.*

Tehama County Medical Society
President, James L. Faulkner, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Charles M. Mathias, 515 Kern Street, Tulare.
Secretary, James C. Malcolm, 1501 West Main, Visalia.

Ventura County Medical Society
President, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.
Secretary, George H. Arnold. Route 2, Box 12, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, William J. Blevins, Sr., 212 Porter Building, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Joseph D. Lewis, 725 Fourth Street, Marysville.
Secretary, Thomas F. Keyes, 725 Fourth Street, Marysville.
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California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

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BOOKS RECEIVED

Doctors at War. Edited by Morris Fishbein, M.D., Editor of the Journal of the American Medical Association and of Hygeia, The Health Magazine; Chief Editor of War Medicine; Chairman of the Committee on Information of the Division of Medical Sciences of the National Research Council. Cloth. Price, $5.00. Pp. 418, illustrated with photographs and charts. New York: E. P. Dutton & Company, Inc., 1945.

Mass Radiography of the Chest. By Herman E. Hillboe, M.D., Medical Director, Chief, Tuberculosis Control Division, United States Public Health Service; Professional Lecturer on Tuberculosis Control, George Washington University School of Medicine, Washington, D. C., and Russell H. Morgan, M.D., Surgeon (R), Medical Officer-in-Charge, Radiology Section, Tuberculosis Control Division, United States Public Health Service; Assistant Professor of Roentgenology, Absent on Leave, The University of Chicago. Cloth. Price, $3.50. Pp. 288, illustrated. Chicago: The Year Book Publishers, Inc., 1945.

Textbook of Abnormal Psychology. By Roy M. Dorcus, Associate Professor of Psychology, University of California at Los Angeles, and G. Wilson Shaffer, Dean of the College of Arts and Sciences, Lecturer in Psychology, Professor of Health and Physical Education, Johns Hopkins University; Psychologist, Sheppard-Enoch Pratt Hospital, Towson, Maryland. Third Edition. Cloth. Price, $4.00. Pp. 547, illustrated. Baltimore: The Williams & Wilkins Company, 1945.

Proceedings of the Rudolf Virchow Medical Society in the City of New York. Volume III, 1944. Edited by the

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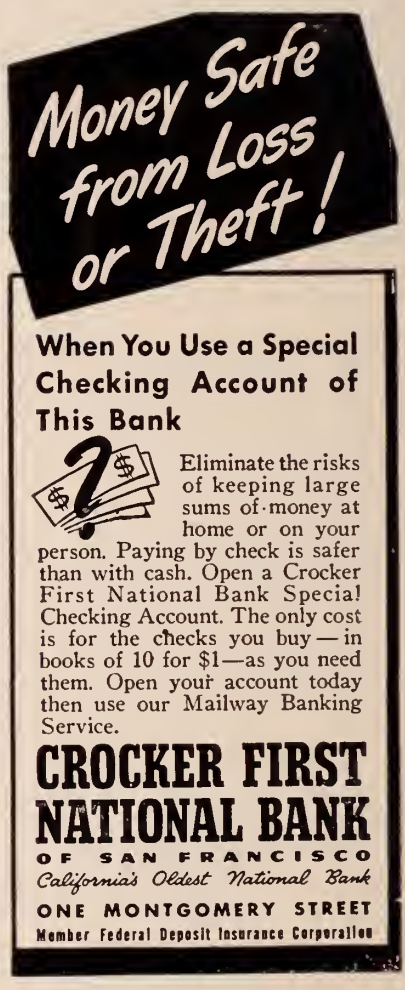
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BOOKS RECEIVED

(Continued from Page 7)

Publication Committee, Franz M. Groedel, M.D.; Bruno Kisch, M.D.; and Erwin Schiff, M.D. Paper. Price, $2.00. Pp. 103, illustrated. New York: Brooklyn Medical Press, Inc., 1945.

On Modern Syphilotherapy with Particular Reference to Salvarsan. By Albert Neisser. [Sammlung zwangloser Abhandlungen aus dem Gebiete der Dermatologie, der Syphidologie und der Krankheiten des Urogenitalapparates, Band I, Heft 1, 1911]. Translated by Isabelle von Sazenhofen Wartenberg. Biography and Bibliography by Frances Tomlinson Gardner. Paper. Price, $1.00. Pp. 42. Baltimore: The Johns Hopkins Press, 1945.

The Examination of Reflexes. A Simplification. By Robert Wartenberg, M.D. Foreword by Foster Kennedy, M.D. Cloth. Price, $2.50. Pp. 222. Chicago: The Year Book Publishers, Inc., 1945.

Penicillin Therapy Including Tyrothricin and Other Antibiotic Therapy. By John A. Kolmer, M.S., M.D., Dr.P.H., Sc.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry, Temple University; Director of the Research Institute of Cutaneous Medicine; formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania. Cloth. Pp. 302. New York, London: D. Appleton-Century Company, Inc., 1945.

The great Alexandrian anatomist, Herophilus, described the prostate gland.

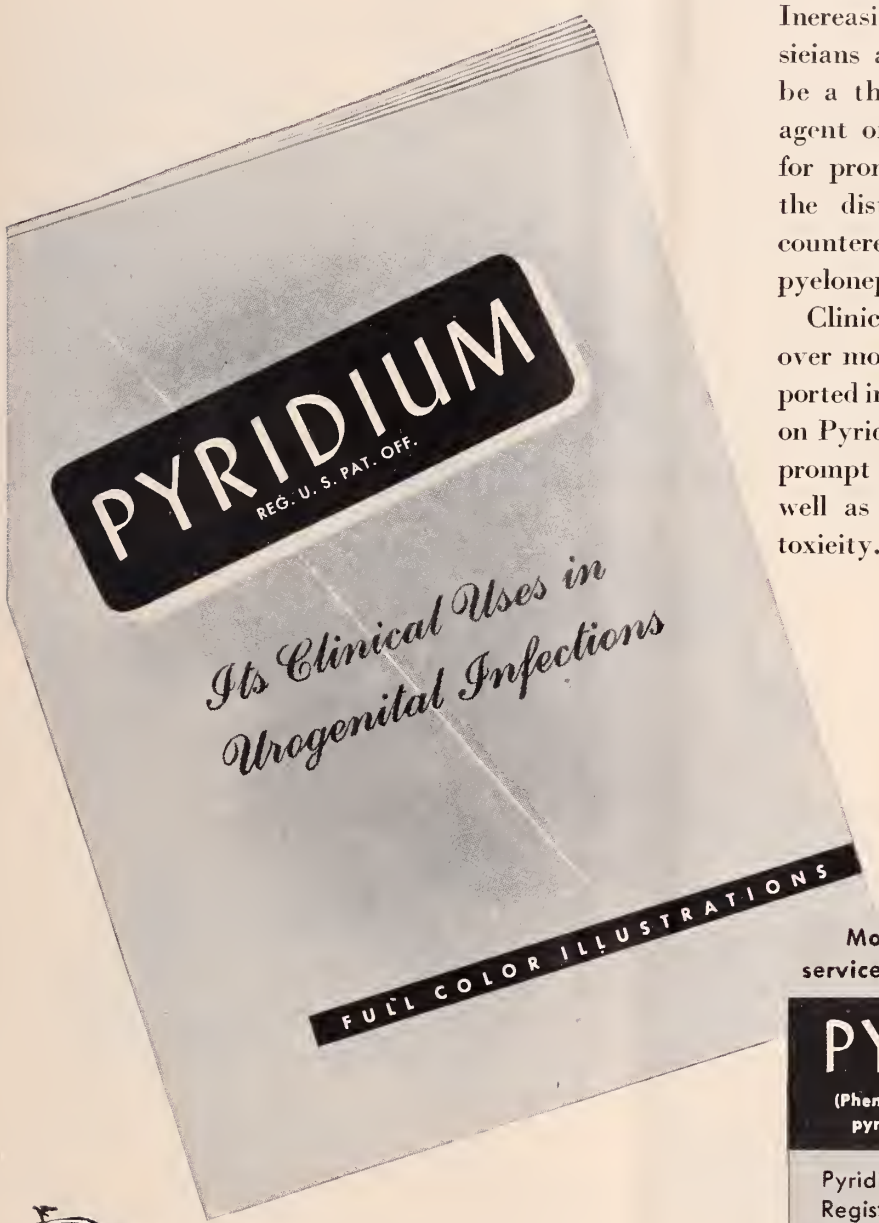
Demosthenes of Massilia (Marseilles) is quoted by Galen in the treatment of malignant pustules.

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* **THE EFFECTS OF SULFONAMIDES ON THE BLOOD**—from American Journal of Clinical Pathology
* **NUTRITIONAL IMPROVEMENT OF CHILD MENTALITY**—from American Journal of the Medical Sciences
* **MANAGEMENT OF HYPERTENSION**—from Journal of Missouri Medical Assn.
* **AMINOPHYLLIN IN VIRUS PNEUMONIA**—from Stamford Medical Bulletin



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RICHARDSON SPRINGS, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Text Page, 296)

Angeles, Calif.—I have a number of eye lesions due to focal infection which I think will be interesting to report at this meeting.

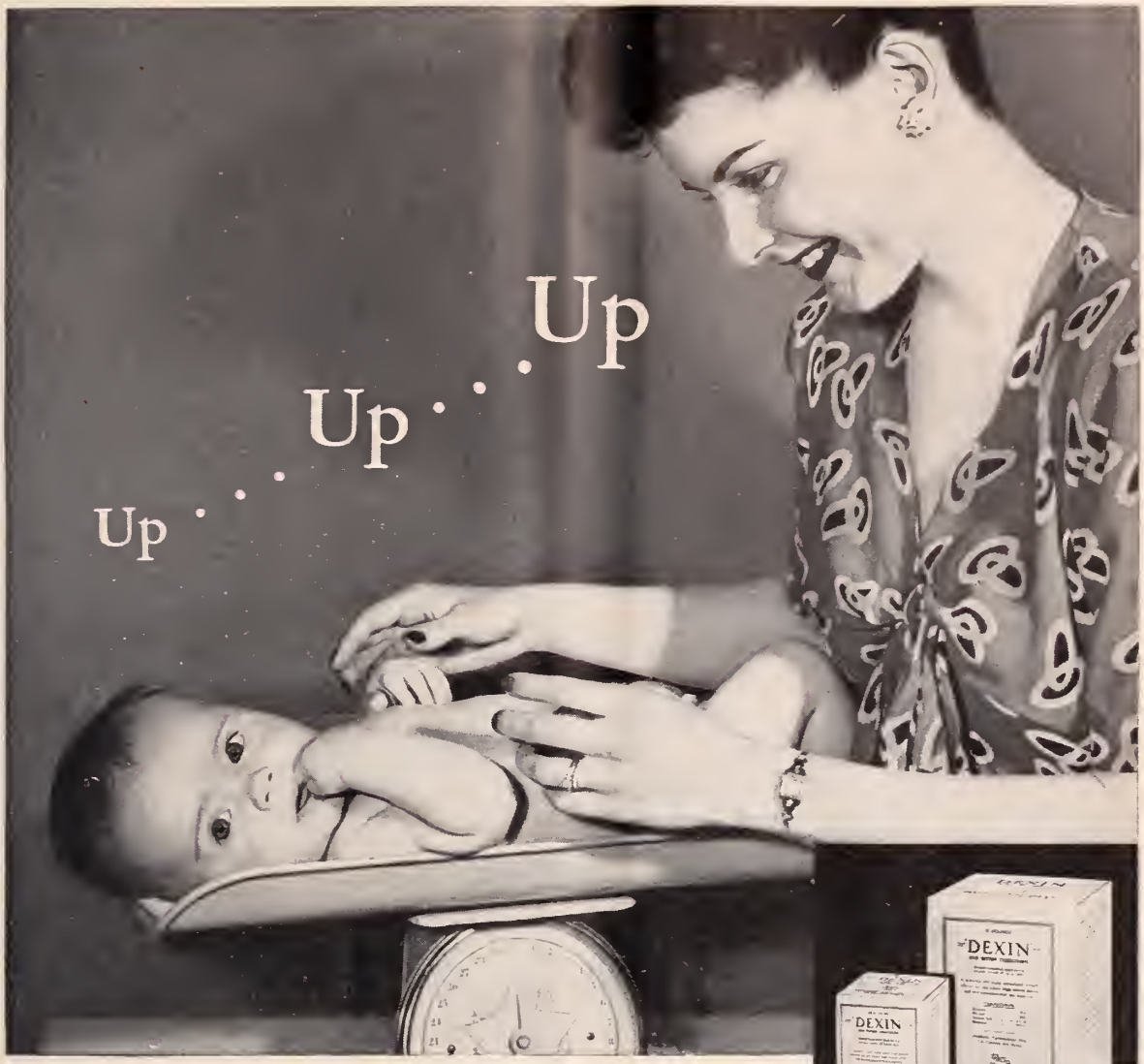
We have come to recognize focal infection as one of the most common causes of a great number of acute ocular inflammations.

In eye work particularly. This has made it possible practically to stop at once by simply removing the cause, attacks that were formerly treated for weeks and sometimes months. . . .

From an Article on "Vaccine Treatment of Typhoid," by Edward von Adelung, M.D.—This is a clinical report on twenty cases of typhoid fever, a portion of an epidemic which occurred in Contra Costa County, Calif., during November and December, 1917, the infective agent being water borne. With the exception of one man, a clerk, all of the patients were laborers. Because of their disinclination to stop work, they came under medical care some days or weeks after fever had developed. This fact classifies them with those commonly recognized as offering a poor prognosis. Their ages ranged from 19 to 59, and they were in good physical condition. None of them had had typhoid.

From an Article on "Achylia Gastrica—A Note Regarding Treatment," by Elbridge J. Best, M.D., San Francisco.—The term achylia gastrica was applied by Einhorn in 1888 to a certain number of cases that revealed, on gastric analysis, an absence of free hydrochloric acid, and gastric ferments with a total acidity

(Continued on Page 16)



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Allen H. Williams, M.D. Medical Directors Albert T. Voris, M.D.

TWENTY-FIVE YEARS AGO

(Continued from Page 14)

of about 10. Because these cases showed no other pathology, the gastric condition was considered a separate entity due to a neurosis.

During the succeeding years, the diagnosis has been made many times on entirely insufficient evidence, such as the mere absence of HCl in one sample of stomach contents, and an incomplete physical examination.

From an Article on "Some Comparisons Between War Neuroses and Those of Civil Life," by Thomas G. Inman, M.D., Assistant Clinical Professor of Medicine (Neurology), Stanford Medical School, San Francisco, Calif. Neurologist to Navy Base Hospital No. 2.—When your Secretary invited me to read a paper before your society it was thought that a review of our experience with war neuroses might be of interest. It seems that these conditions are not so very different from the functional nervous disorders encountered in civil practice and if the similarity is firmly established such lessons as have been learned during the recent conflict may aid us in our work at home. Men engaged in your line of work will recognize that the war neuroses present some points of special interest and that the neurotic individual who is the cause of so much trouble in railroad accident work is not so very different from the patient suffering from some form of shell shock. Abundant experience, under new conditions, has served to throw additional light on our conceptions of the neuroses from which it is hoped suitable methods of treatment may be evolved. . . .

Excerpt from Correspondence: What the Doctors Think of the Indemnity Defense Fund:—

San Francisco, February 10th, 1920.

To the Editor: Enclosed please find my check for $15.00 together with my note for the further sum of $15.00 for the Indemnity Defense Fund and I wish to thank you for the reminder sent me.

I believe that the present method of bringing it to the attention of all the physicians is going to be productive of good results. I know it was just what I needed—although I had been thinking seriously of it for some time.

With best wishes for the success of the Indemnity Defense Fund, I am,

Respectfully yours,
(Name of Member.)

* * *

To the Editor: Enclosed find check for Thirty Dollars that I may become a member of the Indemnity Defense Fund, as per letter of February 9, 1920.

Thanking you for calling my attention to my laxity in not joining earlier, still today I have a clean slate regarding malpractice suits but one can never tell.

Sincerely yours,
(Name of Member.)

Excerpts from Los Angeles County Society Proceedings:

"Hospital Standardization," by Dr. Dudley Fulton.—Dr. Fulton said that by higher standards for medical

(Continued on Page 20)

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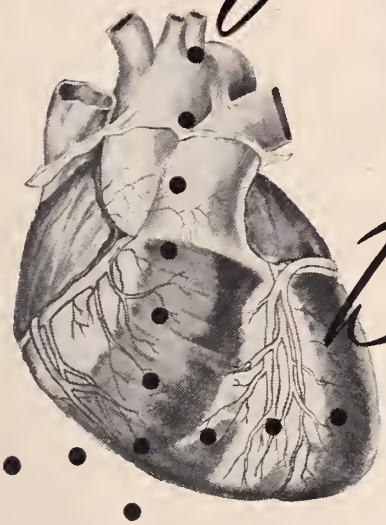
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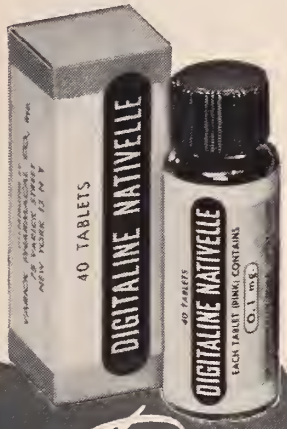
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*Gold, H.; Cattell, M.; Modell, W.; Kwit, N.T.; Kramer, M.L., and Zahm, W.: Clinical Studies on Digitoxin (Digitaline Nativelle) with Further Observations on Its Use in the Single Average Full Dose Method of Digitalization, J. Pharmacol. & Exper. Therap. 82:187 (Oct.) 1944.



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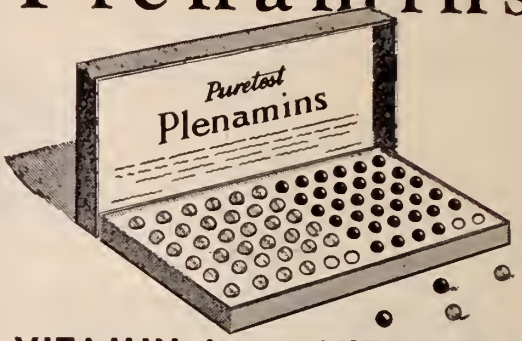
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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

colleges, one hundred and sixty odd colleges were eliminated. The standardization of hospitals is more complicated than that of medical colleges. There are some 4,000 hospitals in the United States. There are fifteen organizations at work on this subject. California has received commendation of the A.M.A. The subject has been fostered by the League for Conservation of Public Health. . . .

Nursing Situation.—Dr. William Duffield, chairman of the Committee on Nursing Survey reported that the committee had several meetings. For several years past there were not enough nurses due to various reasons such as higher requirements, etc. The difficulty is a general and not merely a local one.

The nurses now ask for 12 hours a day and the fee schedule is general nursing at $5.00 per day of 12 hours, for contagious cases $6.00, and for smallpox $10.00.

Dr. James Percy of Chicago—During the influenza epidemic, Dr. Percy said he recommended that a secondary class of nurses be supplied. Nurses usually only follow the occupation to get into the superintendents' places.

U.S.C. Buys Medical College.—The present site of the U.S.C. College of Physicians and Surgeons, 232 feet frontage on Washington street adjoining the Angelus Hospital, has been purchased for $50,000. Dr. George F. Bovard, president, plans additional buildings, including one for clinics, at a cost of $100,000.

(Continued on Page 22)

"POISON IVY is prevalent east of the Rocky Mountains . . .
POISON OAK prevails along the Pacific Coast."

—New and Nanofficial Remedies: Allergenic Preparations, Chicago, American Med. Assoc., 1944, p. 56.



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Kerr and Chamberlain (Nelson's New Loose-Leaf Medicine, 1943) state:

"Patients who have received no digitalis within two weeks may have attacks of paroxysmal auricular tachycardia terminated by a single 'saturation' intravenous dose of about 6 cc. Cedilanid."

R. M. Tandowsky (American Heart Journal, January 1945) states:

"Each patient was seen during a paroxysm, and this paroxysm was treated with the full digitalizing dose of Lanatoside C (1.6 mg.) intravenously; in one case the drug was given orally (6.5 mg.) over a period of forty-eight hours. Response to this medication, with re-establishment of normal sinus rhythm, occurred in all cases within a period of forty-eight hours."

Sokolow and Chamberlain (Annals of Internal Medicine, February 1943) state:

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

From an Article on "The Reason Why Twelve Patients Entered the Sanatorium Too Late," by Robert A. Peers, M.D., Colfax.—Note: The following article is so good and so worthy of attention from physicians, that it is reprinted from "The Tea Bee," February, 1920.

Number one thought his cough was "bronchial." He was sure it could not be due to tuberculosis as "There was no consumption in his family." So he tried to "wear it out." When he himself was worn out and consented to enter a sanatorium it was too late.

Number two knew that his chills and fever were due to malaria. The cough he said was "only the cough that goes with malaria." So he took "Mother Skinnem's Chill Tonic" and the tubercle bacillus worked while he slept. Later he slept with his fathers. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 296)

illegally in revoking licenses of 22 chiropractors last year, the Superior Court ruled today. The cancellations were ordered by the board on grounds the licenses had been issued after examinations by single board members in 1942. New members of the board appointed by Governor Earl Warren held that only the entire board could give the tests. However, Judge Malcolm Glenn held that the chiropractors were entitled to a hearing before the revocations." (Whittier *News*, March 1, 1945.)

"The third district court of appeal today took under submission briefs filed in the appeal of M. A. Thompson, North Sacramento chiropractor convicted in the superior court last August on two counts of abortion. In support of their appeal, attorneys for Thompson charged highly prejudiced and inadmissible evidence was admitted by the court. It was asserted that the district attorney's office made an 'over-zealous effort to bring about the conviction of the defendant at all costs.'" (Sacramento *Bee*, March 6, 1945.)

Promiscuous Women Are Major Factors in Venereal Spread

An analysis of San Francisco's Women's Court cases to convict sexual promiscuity as the most vital factor in the spread of venereal disease was presented to health officials at a U. S. Public Health Service postwar conference, in St. Louis, at a recent meeting.

Addressing the conference, Dr. Richard A. Koch, chief of the city's venereal diseases division, urged a venereal control program "related not only to medicine and public health, but also to welfare, church, law enforcement, education and public understanding, and supported by all agencies, private and governmental."

Dr. Ray Lyman Wilbur, president emeritus of Stanford University, collaborated with Dr. Koch in preparing the analysis and program.

Of 1,680 women examined at San Francisco's Women's Court from March, 1943, through

(Continued on Page 28)



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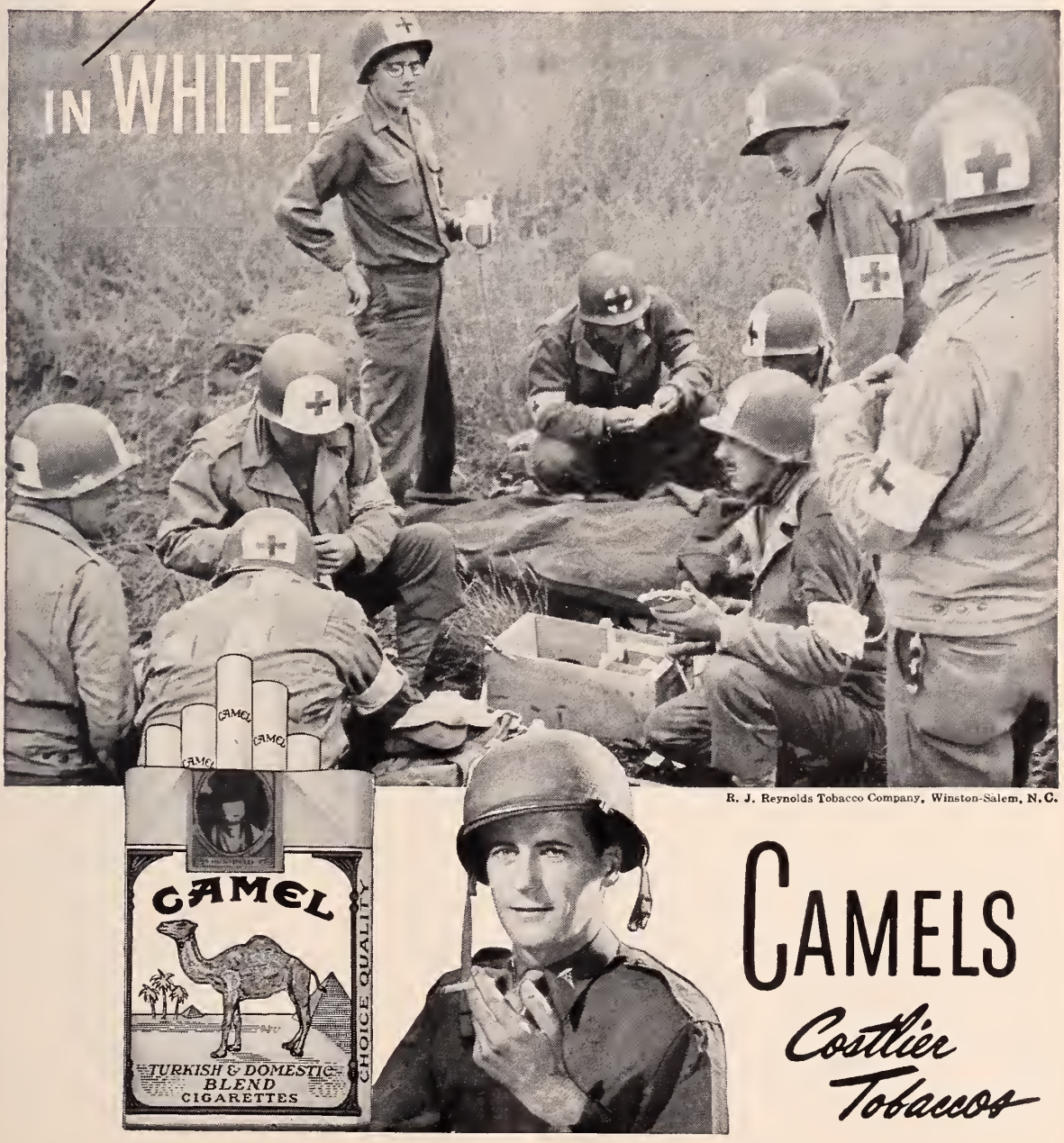
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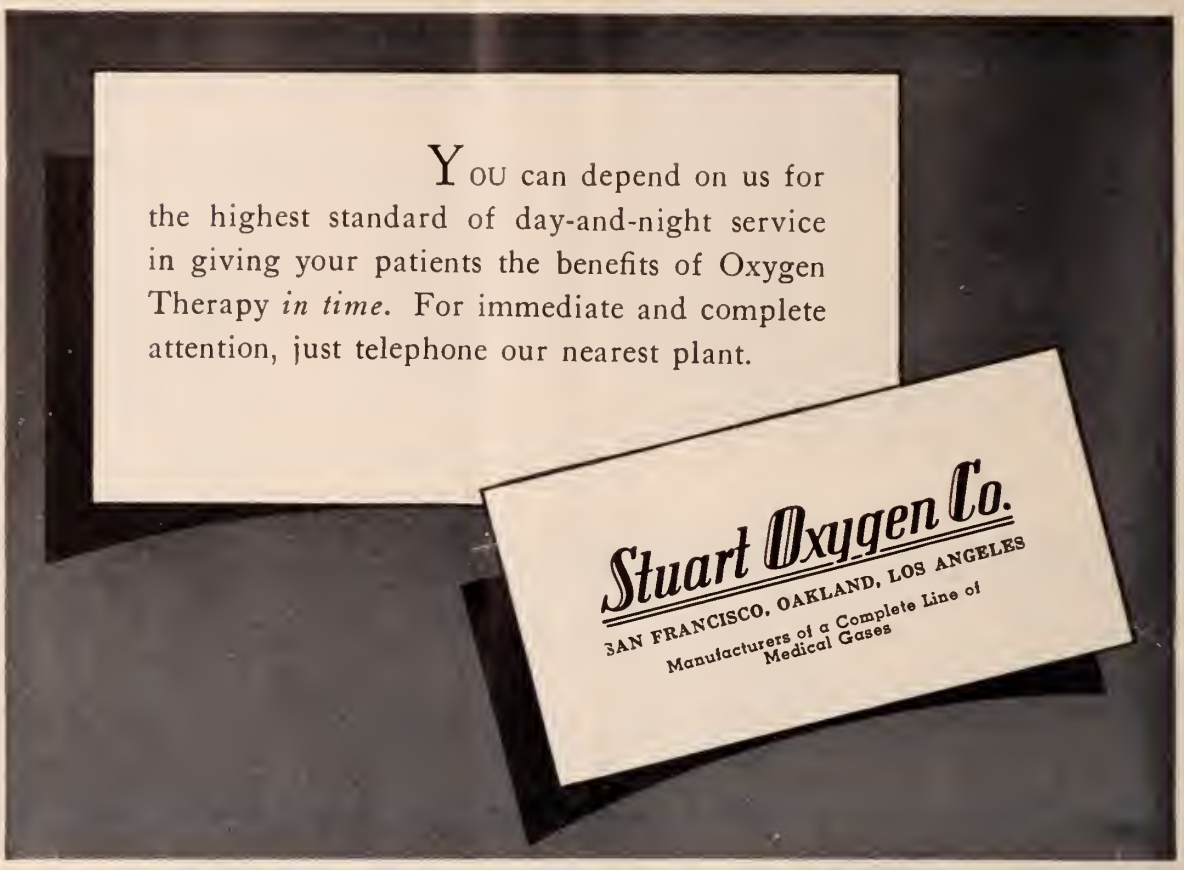
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PROMISCUOUS WOMEN ARE MAJOR FACTORS IN VENEREAL SPREAD

(Continued from Page 22)

Sept., 1944, 53 per cent were promiscuous; 22 per cent were prostitutes; 20 per cent were alcoholics; and the remainder were classified as drug addicts.

Of the total, 56 per cent came from broken homes.

Some religious affiliation was stated by 84 per cent. In most instances this was only an expression of faith, according to Dr. Koch, who added that detailed analysis of 90 of these patients showed 68 to be religiously inactive.

At the same time Dr. Koch referred to the results of serologic examinations of 14,354 new employees of a San Francisco war industry, "representing mainly a transient population which did not have its roots deeply established in a communal environment."

Statistics showed 11 per cent to have venereal disease, while an examination of 3,610 workers from the same industry before the introduction of large masses of migratory workers showed only a 5-plus per cent incidence.

Dr. Koch used these statistics to illustrate the high incidence of syphilis among the relatively promiscuous transient.

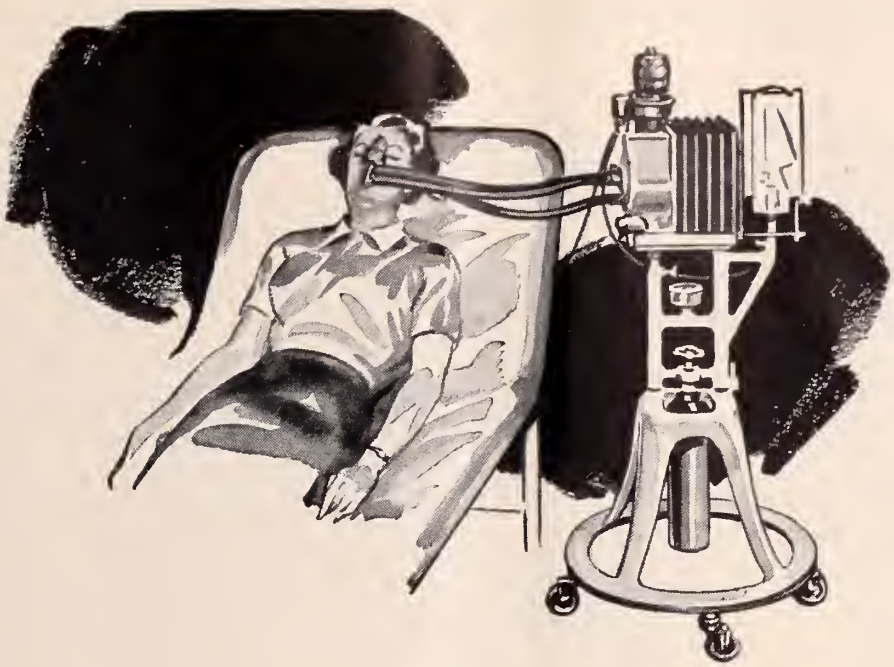
While praising the effectiveness of the new "lethal weapons of the medical profession in combatting venereal disease," Dr. Koch warned, however, that penicillin is not likely to be a panacea for the cure of both syphilis and gonorrhea.

"As the sulfonamides have failed, so penicillin may fail," he said. "A rigid criterion of cure in both diseases is indispensable to adequate treatment and control."

Tying venereal disease to juvenile delinquency and calling on health officers to help control the "environment of youth," Dr. Koch outlined a 16-point all-round program of community control:

1. Establishment of the family as a secure cultural unit.

(Continued in Back Advertising Section, Page 34)



In Hyperthyreosis, too

The symptom complex of increased appetite, exaggerated psychomotor tension, hyperhidrosis, and loss of weight, in addition to spelling thyrotoxicosis, also reflects the intense metabolic activity characteristic of this condition. Utilization of nutrients may be 50 per cent above normal.

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EDITOR GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker (Chairman) Fresno 1946
F. Burton Jones Vallejo 1947
R. H. Sundberg San Diego 1948
Secretary-Editor ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

V. PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Continued)

Proponents of Compulsory Sickness Legislation Were Defeated in the Initial Battle.—The California Legislature may continue in session throughout the month of May, or may even carry on into June. Until the 56th Session adjourns, the enactment of some kind of compulsory sickness insurance law is always a possibility.

In the initial struggle at Sacramento, carried on largely before the Assembly Committee on Public Health, the proponents of the compulsory health bills were defeated; the Assembly Committee by a vote of 7 to 3, refusing to report out Governor Warren's bill (A.B. 800), or the C.I.O. bill (A.B. 449). A strenuous effort by the sponsors and spokesmen of the two bills to secure 41 of the 80 Assembly votes needed to withdraw the bills from the Committee, in order to secure a vote on the Assembly floor, was not successful, the State Administration and the C.I.O. forces alike going down in defeat. (Item XIX in the April issue of CALIFORNIA AND WESTERN MEDICINE, on page 197, and other items in the current number give additional information.)

While the battle concerning the controversy was on, the issue received much newspaper comment. It may be said that the members of the Assembly did not enjoy the hard pulling and tugging involved in the struggles over the compulsory sickness bills; particularly so, since Republican Assemblymen found themselves in the undesirable position of being obliged to oppose Republican Governor Warren, he having strenuously advocated compulsory sickness legislation as an important and immediate need of the people of California.

* * *

Proposal for an Interim Study Committee of the Legislature.—The discussions at Sacramento and elsewhere, led to the introduction by Legislators of bills that would authorize the appointment of an Interim Committee of the Legislature, the duty of which would be to make a study of sickness insurance needs of the State, and to report on the same with recommendations to the 57th Legislature, which will convene in regular session in January, 1947. It is possible that such a law may be enacted, if the proponents of A.B. 800 (Warren) and A.B. 449 (C.I.O.)

fail in their present attempts to bring out, for vote by the Assembly and State Senate, a compromise measure embodying elements of each of these two bills.

Up to the time of this writing, the enactment of a legislative bill to have the electorate vote on some form of referendum dealing with compulsory sickness does not seem imminent.

The advocates of the C.I.O. proposals assert, if they are unsuccessful in their efforts at Sacramento, they will promptly circularize petitions among the voters for an initiative compulsory sickness law. That threat cannot lightly be put aside.

* * *

The Task Before the Medical Profession.—From the foregoing, it is evident that the battle concerning compulsory sickness legislation is still joined. More than that, and not to be forgotten by members of the medical profession, is the fact that the agitation for sickness insurance legislation will continue to be carried on during the years ahead, until some kind of law designed to make adequate medical and hospitalization care available for all citizens—with special reference to the indigent, the medically-indigent, and the near medically-indigent groups—will have been enacted.

The task of the medical profession is to formulate provisions that will provide fullest possible medical care for all citizens, without lessening the quality or standards of medical service. Since the bills submitted by Governor Warren and the C.I.O. would make for greater inadequacies in medical care than exist at present, they are being and must continue to be opposed.

If an Interim Committee of the Legislature is appointed—and that seems possible—the medical profession must be in position not only to give irrefutable facts and reasons concerning the public health menaces involved in the Governor Warren and C.I.O. bills, but to submit an outline of procedures whereby adequate medical care would be made available to all citizens of the State, without destroying the best elements of medical practice as now carried on.

The battle is not over. There is much work ahead. The active thought and aid of every Doctor of Medicine is solicited and needed.*

Our principal task now is to extend tuberculosis control activities so as to reach the greatest number of workers and their families in the shortest possible time, making full use of all private and public resources. With energetic use and concerted action, the final eradication of tuberculosis from the United States is well within our grasp.—H. E. Hilleboe, M.D., and D. M. Gould, M.D., U.S.P.H.S., *Jour. A.M.A.*, May 27, 1944.

* Items concerning Sacramento and other proceedings appear in this issue for the information of members, and for historical record. (See pages 276-289. Index of items, on page 275.)

The attention of members is also called to the illuminating address given by President Lowell S. Goin, "The Philosophical Background of Compulsory Health Insurance," which appears in the current issue, on page 247.

C.M.A.'S 74TH ANNUAL SESSION

C.M.A. Scientific Sections Held Successful Meetings.—This year's Annual Session of Sunday-Monday, May 6-7, held by the California Medical Association in Los Angeles is now of the past. In spite of the skeletonized program, the scientific and business meetings were carried through in excellent manner. The thirteen Scientific Sections, in co-sponsorship with the Los Angeles County Medical Association, held meetings at which good attendance was present. Addresses and papers to a total of one hundred were given. Many of these will appear in CALIFORNIA AND WESTERN MEDICINE during the coming year. Elsewhere in this issue is given the program, with names of speakers and digests of their papers.

* * *

House of Delegates.—The meetings of the House of Delegates were marked by the introduction of fewer resolutions than in previous years. The special session in January last, and the compulsory sickness legislation now pending before the California Legislature may explain in part why unity was so much in evidence in this May meeting at Los Angeles.

All delegates in attendance were seated. No controversial issue arose to require a re-allocation of voting units.

The directives of the Federal Office of Defense Transportation, requiring that the number of official delegates needing rail transportation be less than fifty, made it impossible for many members from the Northern section of the State to attend. It is to be hoped that next year the travel restrictions will have been lifted, so that C.M.A. members who have enjoyed the annual reunions may again have opportunity to meet colleagues and friends from other sections of the State, and participate in the scientific and other proceedings.

* * *

Retiring and Newly Elected Officers.—With the adjournment of the House of Delegates on Monday, May 7, the term of Doctor Lowell S. Goin as president of the California Medical Association came to a close. However, he was not relieved from responsibilities, since the Administrative Members of California Physicians' Service elected him a member of the Board of Trustees of that nonprofit, voluntary prepayment plan of medical care; and the Board when it organized, elected Doctor Goin as president of C.P.S.,—Doctor Ray Lyman Wilbur of Stanford having requested to be relieved of further duty as C.P.S. president. The House of Delegates and Administrative Members expressed their deep regard for the services so ably rendered during the last several years by Doctors Goin and Wilbur in their respective organizations.

President-Elect Philip K. Gilman of San Francisco, duly inducted into office as president of the California Medical Association for the coming year, was not set free of other duties, since the

C.M.A. Council insisted on reëlecting him to the position of chairman of that body, where he has so efficiently presided in the past.

The new President-Elect is Doctor Sam J. McClendon of San Diego, whose past services for organized medicine in his own district and for the State-at-large made him a worthy recipient of the honor that has come to him.

New members of the Council are Doctor Jay J. Crane, elected to represent the Second Councilor District (Los Angeles), and Doctor Walter S. Cherry of Rialto (San Bernardino County) who becomes a Councilor-at-large.

The Association voices its appreciation to all retiring officers for their loyal services, and expresses to newly elected officials, best wishes for successful administrations.

* * *

Minutes of the House of Delegates.—Most of the scientific meetings were held in the Elks Temple. The facilities of the headquarters of the Los Angeles County Medical Association were also made available for the House of Delegates. The minutes of the proceedings of the House will appear in the June issue of the OFFICIAL JOURNAL.

The House voted to hold next year's session in Los Angeles.

* * *

Resolution of the House Concerning Dues.—The responsibilities of members in civilian practice to colleagues in military service received careful consideration, as may be noted in the resolution fixing next year's C.M.A. dues at one hundred dollars. The resolution giving the reasons for the increase in State Association dues, which was also unanimously adopted by the House of Delegates, follows:

"With respect to the annual dues for next year, the Council in submitting its recommendation to the House, has been guided by the following circumstances:

"(a) Loss of revenues in the past three years, due to waiver of dues of members in the Armed Services, now numbering over 2,200.

"(b) Need for adequate funds to aid doctors returning from the Armed Services and, in general, to assist during the inevitable disruption of relocation from war- to peace-time practice.

"(c) Need for adequate funds for postgraduate studies, and refresher courses for doctors whose practices have been restricted, due to military service or work in war industrial areas.

"(d) Need for further funds to promote more widespread participation in voluntary medical and hospital prepayment plans; and

"(e) Necessity of reëstablishing the reserves of the Association, which are being constantly diminished by costly national and state public relations activities and increased cost of operation of all Association functions.

"In view of the foregoing, the Council unanimously recommends that the annual dues for 1946 be fixed at one hundred ($100.00) dollars per member."

EDITORIAL COMMENT†

CHEMO-PROPHYLAXIS OF INFLUENZA

Considerable theoretic interest is attached to the current demonstration by Wheeler and Nungester[1] of the University of Michigan that intraperitoneal administration of atropine sulfate has a marked prophylactic effect on experimental influenza infection in mice. The PR-8 strain of influenza A virus was used in these experiments. The mice were inoculated under light ether anesthesia by intranasal instillation of 0.05 cc. of a 1:100,000 dilution of a suspension of infected mouse lungs, the inoculum containing approximately 1 m.l.d. of influenza virus. Mice were given 0.1 cc. of a 1 per cent solution of atropine sulfate intraperitoneally from 15 minutes to 12 hours before inoculation. This represents about one-sixth the toxic dose for mice, or the equivalent of about 30 times the therapeutic dose for man. In control groups without atropine the death rate averaged about 51 per cent. Among the 120 mice given atropine from 15 minutes to 3 hours before inoculation the average death rate was but 22 per cent. With those given atropine from 6 to 12 hours before inoculation, no reduction in death rate was noted. Atropine was also without therapeutic effect if given from 5 to 20 minutes after inoculation. As a possible explanation of the ability of atropine to increase resistance to influenza virus, Wheeler assumed that aspiration of mucous secretions, present in excess following ether anesthesia, aids in the establishment of the virus infection. Inhibition of this excessive secretion would therefore lessen the severity of the virus infection. This finding is in accord with his previous demonstrations of the increased virulence of virus suspensions by the addition of gastric nusin.[2] The finding is of suggestive clinical interest as throwing new light on the probable mechanism of air-borne influenza infection.

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REFERENCES

1 Wheeler, A. H., and Nungester, W. J., Science, 100:523 (Dec. 8), 1944.
2. Wheeler, A. H., and Nungester, W. J., Science, 96:92, 1942.

It is the depth at which we live, and not at all the surface extension that imports.
—Emerson, *Society and Solitude: Works and Days.*

I wish to preach, not the doctrine of ignoble ease, but the doctrine of the strenuous life.
—Theodore Roosevelt, *Speech*, Hamilton Club, Chicago, April 10, 1899.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.



LOWELL S. GOIN

President, California Medical Association

1945

SALUTATION FROM PRESIDENT GOIN

To Members of the California Medical Association—

Greetings:

The 74th annual session of the California Medical Association finds its members once more engaged in an attempt to prevent the socialization of their profession. It is a matter of great pride to observe them standing shoulder to shoulder, with only the most trifling defections from their ranks, sturdily defending the profession of medicine and the health of the people of California.

The House of Delegates has indicated a course which the California Medical Association should steer and the officers of the Association are pursuing that course with vigor. Your officers thank every man for his support and solicit its continuance.

Fraternally yours,

LOWELL S. GOIN, M.D., *President.*

ORIGINAL ARTICLES

Scientific and General

THE PHILOSOPHICAL BACKGROUND OF COMPULSORY HEALTH INSURANCE*

Lowell S. Goin, M. D.
Los Angeles

THE Constitution of the California Medical Association enjoins upon the president the duty and the privilege of the delivery of an address at the annual meeting of the Association; a task that is a duty because our law imposes it, and a privilege because it gives to one about to make his final official appearance the opportunity of communicating to his fellows any thoughts which he may hold to be significant.

It had been my intention, earlier, to review some of the great accomplishments of Medicine; to deliver a panegyric upon its glories—an encomium upon its achievements. But, as you all know, only a few months ago the specter of Compulsory Health Insurance again appeared and, as we gathered our forces to resist it, some of the ominous portents—the sinister implications of this socialistic proposal became so apparent that I deem it my serious duty to call them to your attention.

Whenever the American people have been presented with the collected Marxian doctrines called Socialism, they have rejected them emphatically, and the Socialist party has never been a serious contender in the political scene. But the social-economic planner has made an interesting discovery: that if the individual doctrines are wrapped separately, and neatly and attractively labeled "social progress," the same electorate which rejected the group may sometimes be persuaded to accept the single article. It is thus that the socialization of the Republic is taking place, and I intend to show you the present scope of the process, and the important part played, or to be played, by Compulsory Health Insurance.

PROPOSALS OF PLANNERS

The planner, about whom I shall have something to say later, professes to believe that there is an urgent need for the enactment of a law establishing a system of compulsory health insurance; that the urgency is shown by the present state of health of the people, and that the public health would be greatly improved if the people were allowed to enjoy the benefits planned for them by the far-seeing altruists who are the proponents of such legislation. I should like now to attempt the refutation of these arguments and, if I am successful in refuting them, examine the motivations which remain after the more obviously apparent motives have disappeared. Whether the true motives are actually those alleged is, I believe, a matter of considerable moment to us, and of greater importance to us as citizens—as Americans—than as members of the profession of Medicine. I say this because, if compulsory health insurance were enacted into law, and if it did have the beneficent effects its proponents profess to believe it would have, then we physicians, as members of a profession which has always striven to prevent disease, to prolong life, and to alleviate pain and suffering, would rejoice. If such legislation failed of its objectives; if, as seems almost certainly the case, the health of the people were harmed rather than helped, then we could, under one condition, change the law and restore the system of free enterprise which has so well cared for the health of our people. I say, under one condition; namely, that we remain free men. But Socailism does not intend that we shall remain free. As long ago as 1845 DeTocqueville saw this and said that democracy extends the sphere of individual freedom, while socialism restricts it. Democracy, he said, attaches all possible value to a man; socialism makes him an agent —a mere member. I do not mean to argue that the enactment of compulsory health insurance will, in itself, cause us to lose our freedom, but that it is, as I hope to show you, an integral part of a social philosophy which looks to the submerging of personal freedom in the all-powerful state. Remember too, that all history shows us that a sociological error once enacted into law is not repealed, but is rather compounded by amendments, new rules, directives and decrees.

It is very fashionable at the moment to maintain that the health of the American people is in a deplorable state and one would think, to listen to the professional do-gooder, that people were dying like flies of untended illness and that merely to look at people in the street would make one shudder. It is argued that the cause for this terrifying condition is the interposition of a financial barrier between the sick person and the doctor, and that all that is needed to greatly elevate the standard of health in the United States is the removal of that barrier. The most popular argument at the moment is that which the planners like to call "the five million 4F's"; that the rejection by the Armed Services of this enormous number of young men presumably in the prime of life reflects the deplorable state of our public health as nothing else has been able to do.

MEDICAL NEGLECT EXAGGERATED

I may remark in passing that it is strange that neither my medical friends nor myself ever come in contact with the cases of medical neglect which are so frequent in the literature of the proponents of compulsory health insurance. In San Francisco, compulsory health insurance is actually in existence, having been established some years ago by city ordinance for all municipal employees. It is interesting to note that these persons are cared for by the same physicians who serve private patients and that in spite of the fact that no financial barrier between the municipal employees and the physicians exists, the incidence of ruptured appendices is materially higher among them than among the private patients of the same physicians.

SELECTIVE SERVICE STATISTICS

Since the five million 4F's are so frequently invoked, and since it is at first glance so shocking a figure, let us examine it in some detail. One difficulty with the argument is that intellectually it is not very honest. In Senator Pepper's interim report the figure is announced on page one not as five million, but as four-and-one-half million but on page three of the same report the graph discloses the true figure to be 4,217,000. An error of 13½ per cent can scarcely be considered insignificant. Of the total number rejected 444,800 were rejected as manifestly disqualified, that is to say the totally blind, the totally deaf, the deaf-mutes, the legless, the armless and so forth. It seems perfectly obvious that no program of medical care could have influenced this figure. 701,700 were rejected for mental disease. Again I don't know of a program of medical care which would have prevented mental disease in these unfortunate people. 582,100 were rejected for mental deficiency, that is to say that they

* Address of the President, California Medical Association, given before the First General Meeting at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

were the imbeciles, the idiots and the morons. The most casual knowledge of eugenics would persuade anyone that this group does not constitute a medical problem, and these three groups together reach the large total of 1,727,600. When these have been excluded there remain 2,426,500 or somewhat less than half of the originally claimed five million. Of this group 320,000 were rejected for muscular-skeletal defects, that is to say the clubfoot, the paralytic, the withered arm, the congenitally dislocated hip and so forth. Again I wonder what program of medical care might have made this group fit for military service. 280,000 were rejected for syphilis. The statute books are already loaded with laws regarding syphilis. There is probably not a community in the United States in which a person afflicted with this disease cannot secure treatment from the Department of Public Health. How, then, would compulsory health insurance have eliminated this group? 220,000 were rejected for hernia. Hernia is a congenital defect and if a person is born with a defective inguinal or femoral canal he is likely to have a hernia and medical care has nothing whatever to do with the occurrence of hernia. 160,000 were rejected for "eyes." Since eyes would seem to be useful adjuncts to men who were to be soldiers or sailors I presume that this means defective vision. If one is born with an eyeball too long or too short or one which is not a globe one will either wear glasses or not see very well and medical care has nothing whatever to do with it. Thus about one million more have been eliminated and the number of rejections on a basis of lack of medical care is about 1,500,000. Whether any program of medical care would have materially reduced this number is problematical. If the proponents wish to rest their case upon the need shown here (and they have made a great deal of it), I am content.

EXPERIENCE OF EUROPEAN SYSTEMS

Even if one admitted the need of a health insurance program it would be well to know in advance whether it would actually achieve the objects for which it is intended. Since compulsory health insurance plans have been in effect in various parts of the world for considerable periods of time it should be possible to discover the effect that such plans have upon public health by examination of the morbidity and mortality tables of such countries as enjoy the benefits of compulsory health insurance. Germany and England are countries which may reasonably be compared to our own being as they are, highly industrialized nations with large populations. Compulsory health insurance has been in existence in Germany for nearly sixty years and in England for nearly thirty-five years. Since so much has been made of the rejections for the Armed Services it will be interesting to compare these rejections with those in England. About 38 per cent of those called for induction in the United States were rejected for physical reasons. In England, although the standards for the armed forces are not as high as those maintained in the United States the rate of rejection was 50 per cent and this after England has "enjoyed" the benefits of compulsory health insurance for more than a third of a century.

Diphtheria is a disease about which we know a great deal, including how to prevent it and how to cure it. There are no secrets involved and the German and English physicians know fully as much about the disease as do those in America. Because of these facts, diphtheria constitutes an excellent index for judging the beneficent effects of compulsory health insurance upon the public health. In the last year in which comparable figures were available the death rate for diphtheria in Germany was 11.6 per 100,000 population. The same year in England the death rate for diphtheria was 11.7 per 100,000. But in the United States, without the benefits of compulsory health insurance, the highest death rate reported was 6.0 per 100,000 and in most of our cities it was 4.0. In this instance, at least, the alleged benefits of compulsory health insurance seem to have failed to manifest themselves.

The morbidity tables reflect the tendency of people to get sick. In the United States the rate of sickness is about 20 per cent; that is to say about one out of five people get sick each year. In pre-war Germany the population was almost evenly divided between those who were covered by the insurance program and those who were not. Among the un-insured the expectancy of sickness was identical with that in this country, that is, 20 per cent. But among the insured it was 200 per cent. Apparently the expenditure of the vast amounts of money involved succeeded only in increasing the rate of sickness about ten times. Of course this figure is largely due to malingering for the purpose of collecting the small cash benefits that are received by a sick person and that this is true is shown by the fact that when German money became almost worthless in 1923 the days of sickness as measured by inability to work fell off one-hundred-million. In 1928 a financial stringency made it necessary to impose upon the insured person a charge of twelve cents for the initial visit of the doctor and again the days of sickness fell off one-hundred-million for that year. This sort of thing must be counted among the benefits of compulsory health insurance.

"THE WAY OF HEALTH INSURANCE"

Dr. Nathan Sinai is one of the ablest proponents of compulsory health insurance, and the author of a book called, "The Way of Health Insurance." Remembering that he urges the people of California to avail themselves of the benefits of this socialistic legislation, listen to what he says about the effect of its enactment upon the people's health: "Contrary to all predictions, the most startling fact about the vital statisics of *insurance countries* is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness.

"Various studies in the United States" (and I am still quoting) "seem to show that the average recorded sickness per individual is from 7 to 9 days per year. *It is nearly twice* that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation *of insurance.*" And he adds that it "seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness."

ON THE "DOMESTICATION OF INDIVIDUALISM"

But if the urgency of the need for compulsory health insurance is so poorly established, and if its alleged benefits turn out to be an increase in the amount of sickness, how is it that apparently sincere and intelligent people continue to agitate for its adoption? It is the answer to this question that contains the sinister implications to which earlier reference was made. Compulsory health insurance is a well integrated part of that revolutionary doctrine called "the domestication of individualism"—the taming of the individual—a doctrine which is defined as anything which makes the citizen more subservient to the State. Probably all too few Americans are aware that revolution is now a department of knowledge; that it has its philosophy, its text books, its literature and its intellectuals who are trained in it. Its professors have set down the technique to be employed, and I have just mentioned the rôle of compulsory health insurance.

Among other things to be accomplished (and it is alarming to notice how many of them *have* been accomplished) are the creation of racial hatred, the creation of class consciousness, the debasing of the national currency, the securing of physical control of the gold, and the neutralization of rival authorities, e.g., the courts. Think where the gold is; think of the current value of your dollar; think of the more than two hundred boards whose authority has superseded that of the courts, and notice how well the parts fall together. We are being charmed by beautiful words; by such words as "security," "planning," "freedom from want and fear," and our senses become so dulled that we fail to observe the subtle shifts of meaning that have occurred.

ON MISUSE OF CERTAIN WORDS

"Insurance" is a word which in our common usage stands for thrift, foresight, prudence and regard and affection for one's dependents. These current proposals have nothing to do with insurance by which is meant the pooling of funds accumulated on an actuarial basis to be used as indemnity for predictable catastrophes. A single glance at the problem will persuade anyone that no actuarial basis exists for the collection of funds for compulsory health insurance and that no one, in fact, has the slightest notion of the cost of such plans, but nevertheless, the word "insurance" remains a favorable symbol. "Health" is a word which ranks very high, representing something prized by all and for the maintenance of which no price is too great. But these proposals have but little to do with health, and in fact, even the word "compulsory" is misused since there is nothing in the proposed legislation which compels anyone to seek medical care or which compels anyone to give medical care and the correct name for such legislation is compulsory tax increase. Nevertheless, these words put together represent a favorable symbol since they appear to deal with a matter so vital as health on a principle so sound as insurance. "Planning" is a word which favorably influences us, since "to plan" means to arrange your resources, materials, and operations so as to secure the best possible result. But suddenly the word no longer has that meaning; it means the central direction of all economic activity according to a single plan, laying down how the resources of society should be consciously directed; in short, it means the socialization of American life.

MENACE OF COMPULSORY HEALTH INSURANCE TO OUR COUNTRY

In 1936, Senator J. Hamilton Lewis addressed the House of Delegates of the American Medical Association at its own request. I do not know the reason that the address was made but I was so shocked at his words that I can still repeat them verbatim. He said, "we are compelled to tell you that we do not recognize such a thing as physician and patient. We do recognize an entity called the citizen—a creature of the State." Note the natural superiority of an American statesman. Hitler wrote a large dull book to set forth the theories so neatly stated in these two sentences; a theory which completely reverses the entire practice of American government. It has always been American belief that the State was the creature of the citizen. Social planning proposes that the citizen will become the creature of the State. Such a state would bind us with the golden chains of security holding before us the glittering promises of freedom from want and freedom from fear. A wild bird well tended in a cage has freedom from want and freedom from fear but it does not have freedom.

The relationship of compulsory health insurance to this directed and subtle process of the tearing down of the American republic and the erection of a socialistic state seems to me to be obvious. Because it *is* subtle, it is not too easy to see. But as Abraham Lincoln said, "when we see a lot of framed timbers, different portions of which we know have been gotten out at different times and places, and by different workmen; and when we see those timbers joined together, and see that they exactly make the frame of a house, all the tenons and mortises exactly fitting, and all the pieces exactly adapted to their respective places, and not a piece too few or too many, we find it impossible not to believe that all understood one another from the beginning and all worked upon a common plan drawn up before the first blow was struck."

Thus it is with compulsory health insurance. It is too well integrated with the general plan, it falls too neatly into place, it fits too aptly into the domestication of individualism for all this to be coincidental. It was not by chance that Senator Lewis made his remarks in Atlantic City. If the whole picture seems incredible, remember the words of David Hume—"It is seldom that liberty of any kind is lost all at once." But to lose it gradually will not make our loss more bearable. The rejection of compulsory health insurance is an essential part of the preservation of our freedom, but it is only part. We must point out to our people again and again that security, so-called, it not the highest aim of life—that it can be purchased, but that the price is freedom, and that as Benjamin Franklin said—"a people which would exchange its liberty for a fancied and transient security deserve neither liberty nor security."

1930 Wilshire Boulevard.

CLINICAL-PATHOLOGICAL CONFERENCE*

WILLIAM DOCK, M. D.
Los Angeles
AND
ALVIN G. FOORD, M. D.
Pasadena

CHAIRMAN Mast Wolfson: The Clinical-Pathological Conference will start immediately. We will pass the case history slips. Dr. William Dock and Dr. Alvin Foord will then make their comments.

CASE 1.—J. L. H., male, age 44. Executive of defense plant. Patient admitted to Huntington Memorial Hospital.

Was first seen by his attending physician on March 2, 1943, for the complaint of a sense of pressure in his chest, bouts of epigastric distress and attacks of fever accompanied by frontal headache.

The sense of oppression in his chest was not a pain, and the patient felt that if he could give a hard cough that he would get relief. This symptom had been present for only a few weeks.

The epigastric distress was irregular in its occurrence but had been present for many years. Five years previously an internist had studied him clinically and by x-ray and had ruled out at that time an ulcer. In March, 1939, he had had an appendectomy for acute phlegmonous appendicitis. The epigastric distress was prone to come two or three hours after meals or about midnight, particularly at times when he was working under great stress. Accompanying his distress was a sensation of fullness high in the epigastrium and frequent eructation of a bitter-tasting fluid. There had been no vomiting,

* This is the edited electric recorder transcript of the discussion of three case reports presented at the clinical-pathological conference held at the third general meeting of the Section on General Medicine of the California Medical Association, Los Angeles, May 8, 1944.

In this Clinical-Pathological Conference three cases were considered. Dr. William Dock, Professor of Medicine, School of Medicine, University of Southern California conducted the Conference.

Dr. Alvin G. Foord, Associate Professor of Pathology, School of Medicine, University of Southern California, discussed the pathological findings.

diarrhea or bleeding associated with these episodes. He had an aversion to certain foods. The attacks were promptly relieved by soda or aluminum preparations.

The bouts of fever had been noted intermittently for the past three years and showed no rhythm of interval between attacks. Sometimes several weeks would intervene, and at other times only a few days. He would notice that the attacks would come on chiefly when he was unusually tired and with them would have premonition manifested by frontal headache. The fever following this would last, as a rule, only a few hours and was usually relieved by taking one or two aspirin tablets, together with some alkali. Following a good night's rest he would feel well and would go back to work. He was a heavy smoker and drank alcohol only occasionally. He occasionally took Seconal for sleep, and had drunk large amounts of raw milk for a long time.

Physical Examination: Revealed a wiry, muscular individual who had lost only 10 lbs. in the last three years. He was quite tense and nervous. The only positive findings were a systolic murmur heard over the precordial area including the mitral and aortic areas, and a spleen which was palpable on deep inspiration. His skin and sclerae were clear and showed no evidence of anemia. His electrocardiogram showed a left axis deviation. Hgb. 80. Red count 4,680,000, white 8,800. Sedimentation rate 11,32,48, 72 mm. (Westergren). Kline test and urinalysis were negative. Blood pressure 130/70. He was advised to arrange his affairs for a diagnostic study in the hospital, which he did, and on April 13, 1943, he was admitted to the hospital.

History and Physical Findings: On admission were the same as above. His temperature was normal for three days and on his fourth day he had one of his attacks of fever with temperature reading 102.5. Two days later the temperature was normal. The patient stated that this was typical of many of his attacks which he had had previous to entry. A mild, generalized aching accompanied the fever, but there was no localization of symptoms. There were no added positive findings and the palpable spleen and a slightly enlarged, nontender liver were demonstrated. The precordial systolic murmur was still heard and described by the interne as being heard best in the aortic area. The heart was of normal size. There were no enlarged lymph nodes.

A blood count taken before the onset of his temperature rise showed 14.7 grams, 87 per cent hemoglobin (Newcomer), red cells 5,030,000, leukocytes 9,300, of which 24 were stabs, 19 segmented, 11 monocytes, 39 lymphocytes, eosinophiles 6, and basophiles 1. The red cells were normal in appearance. The day after the onset of the fever his white count was 6,300; there were 30 stabs, 19 segmented, 9 monos, 41 lymphs and 1 eosinophile. No relapsing fever spirochetes were demonstrated. An agglutination test for Brucella abortus was negative. His nonprotein nitrogen, uric acid, creatinine, sugar, chlorides, and CO_2 combining power were all normal. Gastric juice, obtained in fractional samples after alcohol test meal, showed a large amount of mucus. The total highest free acid was 10 and the highest total acid 32. Urinalysis was negative. Gastrointestinal x-rays were negative except for some spasticity in the sigmoid. A gallbladder dye series was negative. A stereo of his chest was negative. B.M.R. was —27. Skin test with coccidioidin and Brucella antigen were both negative. Blood culture taken on May 3rd was negative after 30 days incubation.

Subsequent History: Patient left the hospital after six days study and did fairly well on a program of increased rest, but had three attacks of fever previous to being seen by a consultant on May 22. The possibility of a Pel-Ebstein fever in abdominal Hodgkin's disease was entertained, and x-ray treatment was given over the spleen. The patient stated that this gave him marked relief, and that it got him on his feet and made him feel much better after an attack of fever. In July a small lymph node was found in the left groin, which was radiated and disappeared. No other nodes were at any time enlarged. The patient had lost 10 lbs. in weight. The spleen was easily palpable just below the ribs and the patient did not look as well as previously. However, he continued his heavy duties in his defense plant.

On August 15th, a blood count showed Hgb. of 74 per cent, red cells 3,900,000, whites 5,530. Polys 49, of which 3 were juveniles, 17 stabs, 28 segmented, 40 lymphocytes, 8 monocytes, 2 eosinophiles and 2 basophiles. Urinalysis was normal. In September he had several bouts of fever, in between which his temperature was normal. In October he was still losing weight. X-ray of his chest revealed no enlarged lymph nodes.

He was seen by a clinic in a neighboring city, and the physical and laboratory findings including negative blood culture, were corroborated. While at the clinic he developed bronchopneumonia which responded promptly to sulfadiazine. Following this rales developed at both bases, and breathlessness occurred for which digitalis was administered. At this time the systolic murmur above described was heard and during the decompensation at one time a diastolic murmur was found. The systolic murmur did not change in quality.

On November 13th, he was seen at the Hospital as an outpatient, at which time he appeared much paler than previously, and weaker than whenever previously examined. The hemoglobin at this time was 64.5 per cent, red cells 3,990,000, white cells 5,000. Stabs 37, segmented 17, lymphocytes 32, eosinophiles 3 and monocytes 11. He was given a transfusion, and after 250 cc. had been given, he complained of extreme breathlessness and restlessness, followed by orthopnea and gurgling rales in the chest, and death resulted in a few minutes, on November 13, 1943.

* * *

COMMENTS BY WILLIAM DOCK, M.D.—ON CASE I

CASE 1.—The presenting symptoms are compatible with many systemic illnesses, such as leukemia, and do not necessarily give a clue to localization. Neither the thoracic nor the epigastric distress can be regarded as other than results of illness leading to indigestion.

Bouts of fever, coming when exhausted, have occurred for three years. These might be due to brucellosis, chronic biliary tract disease, or tuberculosis. The fact that this hard-driven man lost so little weight and has no anorexia is surprising, and suggests that this is not tuberculosis or Hodgkin's disease. The murmur over a large area may be due to a valve lesion; one would like to know how loud and harsh it was. The palpable spleen would fit in with bacterial endocarditis, Hodgkin's, or cirrhosis of the liver, but the bouts of fever over three years can scarcely have been due to the first two of these. Later the murmur is localized in the aortic area, and the liver also is palpable—the latter is rare in bacterial endocarditis, and functional aortic murmurs are also rare, but with no thrill, and a normal pulse pressure true aortic stenosis is not likely. The single fever spike, absence of anemia and of red cells in the urine are against endocarditis or periarteritis, while the leucopenia suggests cirrhosis. In the nonalcoholic cirrhoses, bouts of fever are not so rare.

The improvement on x-ray, and the node, which was not biopsied, do not impress me. This sounds more like hepatitis or cirrhosis than tumor or Hodgkin's. The leucopenia is becoming more pronounced, the spleen larger.

The occurrence of pneumonia and of heart failure brings new possibilities to mind, but the apparent recovery from both is remarkably rapid and both diagnoses may have been erroneous. One would like to know about the heart size and the x-rays of the lungs before accepting such diagnoses. Transient diastolic murmurs usually are third sounds or gallops, except in hypertensive crises when aortic insufficiency may occur. Anemia and leucopenia are more marked, the heart apparently still normal in size when he returned for the transfusion, during which he died. This death can scarcely be ascribed to acute heart failure, and an allergic reaction seems most likely.

With no albumin globulin ratios, no liver function tests, the diagnosis of chronic nonalcoholic cirrhosis has no final proof or disproof. Hodgkin's disease remains a possibility. While negative blood cultures do not rule out endocarditis, nothing but the possible presence of an organic valve lesion speaks for such a diagnosis—the long duration of illness, with only rare spikes of fever and no nephritis are very much against it.

Final Diagnosis: Cirrhosis of liver, perhaps with eosinophilia in liver and spleen. Death not due to the primary lesion.

COMMENTS BY A. G. FOORD, M.D.—ON CASE I

Case 1.—Anatomical Diagnosis—Pertinent Findings:

Subacute streptococcal bacterial endocarditis of aortic valve with perforation of valve leaflet and perforation in root of aorta, forming pocket at root of aorta.

Healed, partially calcified rheumatic aortic endocarditis, with mild stenosis.

Hypertrophy and dilatation of heart, weight 450 grams.

Acute splenic tumor, weight 750 grams.

Marked edema of lungs.

Bilateral hydrothorax, 500 cc.

Focal acute interstitial myocarditis.

Generalized passive congestion with central anoxic necrosis in liver.

The principal finding was the presence of irregular, firm, nodular, dull gray vegetations averaging 6 to 7 mm. in height on all of the fibrosed, partially-calcified leaflets of the aortic valve. Perforation through the root of the aorta at the point of attachment of the valve was present, and a pocket 3 cm. across in the soft tissues was present which was lined by dull brown fibrin. The other leaflets were free from evidence of old rheumatic disease or bacterial infection. Areas of acute interstitial myocarditis, in which there were moderate numbers of polymorphs, round cells and macrophages present in both ventricles. Considerable edema and some exudation of fibrin were present in these areas.

The liver weighed 2,400 grams, extended three finger breadths below the ribs and was moderately firm because of diffuse congestion. Microscopically, there was marked engorgement of the centers of the lobules with blood and atrophy, and in places partial necrosis of the central cells, which was interpreted as being evidence of a failing myocardium. No increase in connective tissue was found.

The spleen, which was fully five times normal weight, showed the usual findings of a splenomegaly due to sepsis. There was no evidence of any Hodgkin's disease nor was there any noteworthy enlargement of any of the lymph nodes.

Because of death during the transfusion, the donor's and recipient's bloods were retyped and the cross matching was repeated, and there was found no evidence of any incompatability. Fresh blood taken from the corpse showed no clumping of the red cells, and in the sections of the organs no red cell clumping was noted in the blood vessels.

Of interest to me is the entire lack of petechiae, the intermittency of the fever and, also, the lack of embolic phenomena in the organs at autopsy.

* * *

CASE 2.—E. D., male, age 59. Entered Huntington Memorial Hospital, 3-11-43, with complaint of abdominal cramps, inability to move bowels, and fever.

The abdominal cramps began early on the morning of 3-9-43, and were associated with nausea with some vomiting. On the evening of the first day of his illness he also complained of fever and chills. On admission he had a temperature of 100.2, pulse 92, respiration 22, and blood pressure 124/70. Before the onset of the present illness the patient had had no attacks similar to the present one. However, in 1935, he passed for a short period of time tarry stools, for which he was x-rayed, but no source of bleeding could be found. At that time he drank alcohol in excess at periodic intervals, but between these bouts abstained from liquor. For the last several years he had been suffering from hemorrhoids which occasionally bled.

Physical Examination: Patient appeared acutely ill, moderately pale but not icteric. Head and neck were negative. The heart was of normal size, its rhythm normal and showed no murmurs or thrills. The abdomen was soft, slightly obese and there were no masses palpable, and no rigidity or spasm or areas of tenderness demonstrated. A flat plate of the abdomen showed a little more than the average amount of gas in the colon, but its distribution did not suggest obstruction. Two very short loops of gas-filled small intestine could be seen, but they were not sufficient to warrant the diagnosis of small gut obstruction. A barium enema was given and x-ray showed no pathologic changes in the large intestine.

On admission, *blood count* showed 8.1 grams or 48 per cent hemoglobin (Newcomer); 3,610,000 reds, 18,100 white cells; neutrophiles 88 (stabs 21, segmented 67), monocytes 5, lymphocytes 7. The average diameter of the red cells was slightly less than normal, and all the red cells showed a slight to moderate hypochromia. An exaggerated rouleaux formation was noted. The admission *urine* and several others taken later were essentially negative.

He was given 1 oz. of castor oil the day of admission and passed liquid stools as a result. At no time after this was there evidence of obstipation.

Course.—From the time of his admission until death the patient ran a constant fever, averaging 101 to 102.5, with an occasional rise to 103 or 4, with occasional chills. He was examined by several consultants and at no time was there evidence of any noteworthy changes in the heart, and in the first weeks of his illness the lungs were clear except for a few rhonchi in both lung bases, and two weeks after entrance one examiner found dullness at the right base with coarse rales at the hilar area and throughout the base, without tubular breathing. A few rales were found on inspiration at the left base. The rales were not removed by cough. At this time also there was moderate tenderness in the right upper quadrant, and the edge of the liver was felt 2" below the costal margin. The rest of the abdomen was negative. A large, soft, protruding hemorrhoid was found. There was no enlargement of the lymph nodes, no skin changes and no edema for icterus.

Treatment.—He was treated with intravenous glucose and transfused five times during his illness, the first time 13 days after entrance. Stupes were applied to the abdomen and from March 19 sulfadiazine was used in appropriate doses, but there was no effect on the temperature which continued to average around 101 to 102 with daily fluctuations of about 2°. On March 29th an exploratory laparotomy was done in the belief that the condition might be of gallbladder origin or liver abscess. The stomach, duodenum and lesser peritoneam, pancreas, gallbladder and liver were explored through a right Singleton incision. No abdominal abscess or focus of infection could be found. The liver was moderately enlarged, its surface was smooth, and no area of softening could be felt. No attempt at puncture of the liver was made and no biopsy was taken.

Subsequent Course.—Numerous *blood counts* during his course at the hospital showed a luekocytosis varying from 18,000 to 11,000, and there was always high polymorphonuclear count, from 80 to 90, with a marked shift to the left, some stab counts being as high as 33. The *urine* was at all times free from abnormal findings. Several unformed *stools* revealed a trace of occult blood and slight increase in fatty acid, but no increase in pus cells or parasites. Several *blood cultures* were made. The only one found positive was taken on March 25th and showed 11 colonies of green streptococci per cc. of blood. Several others taken after this were negative. Chemistry showed an icteric index of 7 on March 25th; calcium was 8.6; and plasma amylase was within normal limits—128 mg. Agglutination tests with Brucella abortus antigen, and Wassermann and Kahn tests were negative. On March 15th the blood albumin was 3.7 gms., globulin 2.1 gms. and N.P.N. 22 mg. On April 25th he developed tenderness along the course of the right saphenous vein and a moderate swelling of the right lower extremity occurred, which persisted until death, which occurred on May 17th.

On April 22nd he suffered from pain in his right lower chest, made worse by breathing, and a pleural rub was heard. Dullness and diminished breath sounds were present in the right base. The area of dullness increased in size and on May 3rd 2,000 cc. of blood-tinged serous fluid were removed from the right pleural cavity. This showed scanty sediment in which 80 per cent of the cells were polymorphonuclears. No bacteria were present in smears or culture. Numerous specimens of mucopurulent sputum obtained at this time showed a mixture of green streptococci, stapylococci and occasionally a hemolytic streptococcus. No tubercle bacilli were ever found.

The terminal weeks of his illness were those of sepsis with marked sweating, prolonged fever and prostration. Death occurred on May 17, 1943, approximately 10 weeks after the onset.

* * *

COMMENTS BY DR. DOCK—ON CASE II

Case 2.—The presenting complaint could be due to appendicitis, pancreatitis, bowel obstruction by tumor or chronic granuloma. The old story suggests bleeding from

ulcer, Meckel's diverticulum or tumor. We would like to know whether his blood count fell, whether his spleen was palpable, but all we have is rumor about his x-rays.

Pallor, absence of peritoneal irritation and abdominal masses are the outstanding physical findings. There was no paralytic ileus, no demonstrable lesion of the large bowel. The leucocytosis suggests tumor or inflammation, not cirrhosis, and following the initial bout of trouble, there were no further symptoms of obstruction. However, fever now is the outstanding feature and the liver becomes palpable. This could be cholangitis, after a bout of cholecystitis or pancreatitis; it may all be due to tumor, which would best explain the anemia. Tumors of the large bowel not infrequently escape x-ray demonstration; those of the small bowel usually do. The exploration did not rule out such a tumor, nor did it rule out pylephlebitis. Finally, he developed thrombophlebitis and classical signs of pulmonary infarction. The final decline is typical of tumor with necrosis, biliary sepsis, or pylephlebitis with multiple liver abscesses.

While appendicitis, subsiding quickly but causing local thrombophlebitis and portal thrombosis and sepsis seems the most likely diagnosis, it fails to explain the anemia. If the old bleeding was due to the same lesion that caused death, it must be either a benign tumor, or one of very slow growth with a final spread to the liver. I am unable to make any diagnosis with conviction, since tumor with necrosis, or thrombophlebitis with liver abscess, can both give exactly this picture.

Diagnosis: Carcinoma of bowel, with hepatic metastasis; or pylephlebitis with liver abscesses and the primary lesion probably in the appendix.

Pulmonary infarction, secondary to thrombophlebitis of leg.

* * *

COMMENTS BY DR. FOORD—ON CASE II

Case 2.—Anatomical Diagnosis—Pertinent Findings:

Leiomyoma of upper jejunum, with suppurative softening of center of tumor and abscess formation with perforation into lumen of gut.

Multiple streptococcus viridans chronic abscesses in right lobe of liver.

Streptococcus septicemia.

Suppurative thrombophlebitis of external iliac vein.

Infected infarcts of lower and upper lobes of right lung.

Subacute splenic tumor.

The obvious source of the abscesses in the liver was the myoma in the jejunum, which was spheroid in shape and measured 4 cm. across, a portion of it bulging into the lumen. A small opening extended into a pocket in its center 2.5 cm. across which was filled with thick, green purulent exudate from which streptococci similar to those in the abscesses in the liver were obtained. The liver weighed 1,900 grams and in the right lobe were seven abscesses filled with thick green pus and surrounded by thick layers of yellow granulation tissue; the largest of these areas was 5 x 5 x 3 cm. The rest of the liver showed simple cloudy swelling.

Numerous streptococci were found also in the softened portion of a thrombus, involving the right femoral and external iliac veins.

Apparently the source of the hemorrhage, as far back as 1935, was the myoma in the jejunum.

* * *

CASE 3.—Mrs. H. B., age 35, white, married, female. First entered the Huntington Memorial Hospital on 7-7-43 complaining of some recent loss of weight and strength, pallor and headaches. She was examined in February, 1943, by an examiner at an aircraft factory, and was told that her blood pressure was 230. At that time she had some headache, which had been present since.

Past History: She had rheumatic fever at the age of 14, and was told that she had a "bad heart." However, she was able to lead a fairly normal life during childhood. She had also had measles, smallpox, chickenpox and scarlet fever. At the age of 24 she had tuberculosis, and was in bed for one and one-half years. She made a good recovery and married but had no children. She had a fair appetite but had lost 17 lbs. in the last few months before admission. She had had no abdominal pain or distress, and no change in bowel habit or in the appearance of her stools. Her menstrual history was essentially normal until the last month before admission, when she skipped one period. At the age of 22 she stated that she had blood in her urine, for which she had several urinalyses, but stated that this lasted only a short while. She states that during all her life, until recently she has had urinary burning and frequency, varying in intensity.

In September, 1935, she was cystoscoped by a urologist, who examined her because of a foul-smelling discharge from the umbilicus, which had been present for several years. Cystoscopic examination showed a moderately scarred bladder with a large "golf hole" right ureteral orifice and a smaller left ureteral orifice, both of which admitted easily ureteral catheters. There was no dimpling at the dome of the bladder and no sinus could be demonstrated at the umbilicus. A cystogram showed a normal bladder shadow with reflux up the left ureter. A bilateral pyelogram showed a tendency to duplication of both pelves, and marked dilatation of all calyces and slight reduction in size of both kidneys. The urine at this time was entirely clear and there was no evidence of active inflammation.

Physical Examination: Showed a moderate pallor without edema. Head and neck were not remarkable except for a few slightly enlarged, firm submental lymph nodes. The heart showed a moderate enlargement to the left and the point of maximal impulse just beyond the mid-clavicular line. There were no thrills. A loud apical systolic murmur was present, best heard over the mitral area; rhythm regular, rate 86. The abdomen and extremities showed no findings of interest. One attending man described a faint diastolic murmur heard at the left border, in addition to the loud apical murmur, but no peripheral signs of aortic insufficiency. The lungs were resonant throughout except for an area in the third right interspace where there was slight dullness. No rales were heard.

Laboratory Examination: Hemoglobin 6.8 gms., 40.5 per cent (Newcomer). Red cells 2,400,000, white cells 9,150, neutrophiles 79 (stabs 19, segmented 60), myelocytes 2, monocytes 4, lymphocytes 15. There was minimal change in the morphology of the red cells, all of which were well filled with hemoglobin. First morning urines showed a specific gravity of 1.008 to 1.010, albumin 1+, sugar negative, 6 to 7 leukocytes per h.p.f., no casts or red blood cells. After a 12 hour fluid restriction the specific gravity was only 1.008, albumin heavy trace, no casts, pus cells or red cells.

She was transfused with 500 cc. of blood on 7-7-43 and 7-12-43, with resulting increase in hemoglobin to 54.5 per cent and red cells to 3,300,000. During her second day of hospitalization she had a temperature of 102, third day 101, fourth day 100, and the last two days were afebrile. Her pulse averaged 90 and respirations 20. She was discharged after one week's hospitalization.

Course: She was readmitted on 8-11-43 because of the onset of epistaxis, ecchymoses in the skin and severe hemorrhage from the bowel. She gave a history of also coughing up a small amount of blood in June. She also complained of nausea and vomiting, as well as a moderate dyspnea and of a moderate cough. There had been no bleeding from the urinary tract, and no pain or burning, but she did have to get up once at night. At examination she appeared to be moderately ill, temperature was 99, pulse 90, respirations 20 and blood pressure 160/94. There was a moderate pallor, tongue and gums were clean. The heart showed enlargement to nearly the midaxillary line on the left. There was a rumbling apical murmur. The abdomen was negative. Scattered small purpuric spots were found in the skin. Her hemoglobin was down to 28 per cent, red cells 1,950,000, leukocytes 7,800, polys 90 (stabs 13, segmented 77), monocytes 3, lymphocytes 7. There was a slight microcytosis and minimal hypochromia. Several urine samples showed a low gravity, 1.007 to 1.010, albumin a trace, sugar negative, no red cells and numerous leukocytes. She was given two transfusions of 500 cc. of whole blood and on August 18th 300 cc. and August 19th 400 cc. of red cells suspended in saline solution. On August 20th the patient suddenly had

a generalized convulsion, and on this day her blood pressure was 210/108, pulse 120. Subsequently she showed varying degrees of drowsiness and clonic jerking of her extremities. On August 21st her N.P.N. was 205. During the next two weeks her condition improved slightly and she showed no more evidence of convulsions or drowsiness; her N.P.N. fell to 150 and blood pressure on one occasion was 126/80. Her urine at the end of this time was loaded with pus cells and she was given sulfadiazine 0.5 grams t.i.d. A week later the patient had chills, a temperature of 103 and developed an extensive morbilliform rash. Two days later a scarlatiniform eruption had occurred with temperature going up to 104. In addition there were numerous petechiae and ecchymoses in the skin. Blood platelets were 23,000, the clotting time was 14 minutes by the Lee White method, normal control being 5 minutes. The clot did not retract in 48 hours, while the control clot retracted normally. The bleeding time was markedly prolonged. A blood culture taken during the febrile period showed no growth.

The rash faded and purpuric lesions became more numerous. The patient again developed muscle twitching, increased drowsiness, her N.P.N. reached 218 and she *died on September 14th*, on the 35th hospital day.

During the first week of her admission her temperature went occasionally to 101, but in the following two weeks remained normal. In the last two weeks, however, her temperature reached 102 to 104 every day and the pulse was 100 to 110. Respirations averaged 25.

COMMENTS BY DR. DOCK—ON CASE III

Case 3.—Pallor, headaches and hypertension mean uremia. The life-long history of urinary burning and frequency suggests cystitis and pyelonephritis; whether hematuria was tuberculous, due to cystitis, or to nephritis, is not clear in this case. The pyelograms seem to rule out either old or recent tuberculosis of the urinary tract, but show anomalies and changes compatible with a "burned out" pyelitis. The eye grounds are not reported, but everything else is typical of the terminal phase of uremia with anemia. In the absence of x-rays the condition of the lungs cannot be stated; the terminal fever and purpura could be due to intercurrent infection in the urinary tract and to uremia, or to activation of tuberculosis. The striking drop in blood pressure is more frequent with tuberculosis than pyogenic infection, but some terminal fall may occur with pure uremia.

Diagnosis: Chronic pyelonephritis; uremia; possibly reactivation of chronic pulmonary tuberculosis.

COMMENTS BY DR. FOORD—ON CASE III

Case 3.—Anatomical Diagnosis—Pertinent Findings:

Bilateral atrophic pyelonephritis.

Bilateral marked hydroureter and hydronephrosis without obstruction.

Marked hypertrophy and dilatation of heart, weight 350 grams.

Active chronic ulcerative pulmonary tuberculosis of right upper lobe.

Tuberculous ulcers in terminal ileum.

Caseous tuberculosis of mesenteric and peritracheal lymph nodes.

Bicuspid aortic valve (healed rheumatic endocarditis).

Anemia.

Uremia.

Purpura.

The kidneys were markedly reduced in size, the left measuring 8 x 4.5 x 3 and the right 10 x 5 x 3 cm. Marked dilatation of the pelves and calyces was present, and the parenchyma was markedly reduced in thickness. Widespread fibrosis and round cell infiltration with atrophy of the parenchyma was present in both kidneys, and large numbers of plasma and round cells were present in the thickened walls of the pelves, calyces and ureters. Marked sclerosis was found in the small arteries and arterioles throughout both kidneys. The findings were consistent with a chronic pyelonephritis with destruction of renal parenchyma. The hypertension apparently resulted from the sclerosis of the arterioles and the obstruction to the blood flow through both kidneys.

The tuberculosis in the right lung was active and a small cavity was present in which numerous tubercle bacilli were found. The death occurred primarily from the uremia.

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EPIDEMIC VOMITING SICKNESS (SPENCER'S DISEASE)*

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In California for the last quarter of a century the writer has seen sporadic cases of a disease common to that State, particularly to the warmer portions, and tending to recur in epidemic form in the spring and fall of each year. This disease is generally called intestinal influenza by the doctors and it is noted to show a predilection for newcomers to the community who, as a rule, have it more severely than the natives. It is of interest to the Armed Services in that many officers and their families promptly incur it upon moving to California, and current reports[1] would indicate that it is becoming much more widely disseminated throughout the nation and inciting general interest and study.

While affecting all ages, the disease is relatively rare in persons over forty, and commonest in small children. None die from it, but hospitalization is occasionally required to overcome severe dehydration with attendant acidosis.

SYMPTOMS

Symptoms are of interest in their great variability, and in that adults are much less sick than children and, as a general rule, recover from the acute phase within 24 to 36 hours, which is followed by 2 or 3 days of lassitude, anorexia and weakness before complete recovery. The chief symptoms consist of vomiting, which may be the sole incapacitating symptom present; diarrhea; or both. If only one symptom be present it is usually vomiting; rarely the vomiting is absent and only diarrhea present, but usually both are concomitant.

The disease tends to occur abruptly in one or two members of a family and the others all come down in a similar manner at intervals of 24 to 48 hours until all have had it excepting adults with a previous history of the infection. The latter are usually spared or have an abortive attack lasting only a few hours, and showing only nausea, anorexia, and sometimes vomiting.

Epidemics are occasionally explosive in violence and in one community over 500 cases occurred within three days and then the epidemic subsided. (Eagle Rock.)

Symptoms noted in typical cases in children are:

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† Ed. Note.—Dr. Albert G. Bower is a member of the Los Angeles County Medical Association. He is stationed at the U. S. Navy Hospital at Portsmouth, Virginia. That institution is the oldest hospital in the Navy, having been founded in 1827. During the War Between the States, it was captured by the Confederates, re-captured by the Union Army, and has remained under the jurisdiction of the Navy since that time. The institution has 3,500 beds. and for some time Dr. John Schmoele, also a member of the Los Angeles County Medical Association, has been Chief of the Surgical Service. Dr. Bower has a similar position as head of the Medical Service.

nausea, vomiting, abdominal cramping, and diarrhea. Sometimes there is headache; backache; chilliness and low-grade fever, occasionally reaching 105 degrees rectally; and rarely, a few days of mild acute jaundice. It has not been uncommon for those not fully acquainted with the disease to remove an appendix because of localization of the pain with rebound tenderness upon examination, and at operation the appendix is found to be normal except for a marked scarlet hyperemia which is evenly distributed to the entire gastro-intestinal tract as well. Normal or diminished white blood counts are the rule, and if appreciably raised to high levels after adequate hydration some secondary factor is most usually present or the diagnosis is questionable.

Sometimes there are markedly hyperemic tonsils present, and occasionally bronchitis, or bradycardia. I have never seen a true constipation, though the bowels may not move for a day or two due to excessive and frequent vomiting which preclude the ingestion of food.

ETIOLOGY

Despite numerous investigations upon the parts of many qualified individuals, governmental agencies, and university laboratories, the inciting agent remains unknown, but the consensus is that a virus will ultimately be incrimnated. The usual bacteria responsible for gastroenteritis have definitely been ruled out in the opinions of most competent investigators.

TREATMENT

Treatment in severer cases will have to be symptomatic and it is useless to give anything by mouth, as it induces prompt vomiting. These patients require rest in bed in a quiet room with dextrose solution by venoclysis. As the nausea subsides a few drops of sweetened liquid may be given at very frequent intervals, and increased to sips as tolerated. If vomiting recurs, the procedure will have to be gone through all over again. Physics are contraindicated and so are the sulfa drugs. Milk of Bismuth combined with chalk mixture, U. S. P. IX, has usually been helpful when patients reach a stage where they can sip and retain it. Heat is most comforting when applied to the abdomen.

COURSE

The disease is self-limited and usually over in three days, but occasionally lasts ten. It must be differentiated from the various other types of acute gastroenteritis and food poisoning, and more often than usually mentioned in the literature, from acute conditions of the abdomen, especially acute appendicitis.

Cases are being seen with increasing frequency in the dependents of all armed services, particularly in the members of dependent families recently removed to the west coast, and they are usually diagnosed under the present nomenclature as acute gastroenteritis, which does not tell the true story; but, since the disease is non-fatal, this is not too significant save from the standpoint of gathering accurate statistical and epidemiological data.

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REFERENCE

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God and the doctor we alike adore
But only in danger, not before;
The danger o'er, both are alike requited,
God is forgotten, and the doctor slighted

—*John Owen*

INTERCOSTAL NERVE BLOCK*

ITS RÔLE IN THE MANAGEMENT OF THORACIC CASUALTIES

MAJOR PAUL C. SAMSON†
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THE use of nerve block in the treatment of thoracic trauma has not received the attention to which it is entitled. The previous literature is not extensive and has been covered by Harmon[1] and by De Bakey.[2] Price[3] has used nerve block in controlling pleural pain due to disease. Harmon and his co-workers reported excellent results following *local* injection at the sites of fractured ribs, although apparently they did not appreciate that the relief of thoracic wall pain was a significant factor in helping to improve bronchial drainage. Rovenstine and Byrd[4] employed intercostal *regional* block for the relief of pain. For reasons to be presented below we have usually preferred a type of regional block rather than local infiltration. Wide experience in treating thoracic wounds has been gained with colleagues of an Auxiliary Surgical Group in the Mediterranean theater of war during the past two years, and the value of regional, paravertebral, and local block of the intercostal nerves has been frequently demonstrated. Several hundred nerve blocks of various types have now been performed. This experience has been summarized in part by Fitzpatrick, Adams and Burbank.[5]

Regardless of the type of injury or method of injection, the control of pain remains the basic aim of treatment. Pain has an important bearing on the patient's immediate reaction to injury. Clinical shock may be initiated or may be prolonged by severe pain. Early transportation, so frequently necessary under combat conditions, is greatly facilitated if pain has been controlled; the patient travels more safely and in greater comfort. Second, but always dependent on relief from pain, nerve block helps to secure adequate bronchopulmonary drainage in patients who have excessive secretions and an obstructed air-way. Third, pain and discomfort following thoracic operations are effectively relieved by intercostal nerve injections. Finally, when thoraco-abdominal wounds are suspected, the response to nerve block in some instances may aid in distinguishing between abdominal pain due solely to thoracic trauma and abdominal pain which results from intraperitoneal pathology. Incapacitating pain may be associated with any type of thoracic injury: minor soft tissue contusions or hematomas in the thoracic wall; all varieties of fractured ribs; small penetrating wounds, and severe, lacerated or avulsed wounds. Nerve block may be used to control thoracic pain of any degree or extent. Indeed, the most spectacular results from block have been in patients whose area of pain was widespread.

Heretofore adhesive strapping has been the most frequent means of attempting to control thoracic pain, especially when it has been due to fractured ribs. Adhesive strapping is still required for stabilization in a few instances where multiple anterior and posterior rib fractures have produced a "flail" chest with paradoxical motion. Otherwise it has been almost completely discarded.

* This article has been released for publication by the Review Branch, War Department Bureau of Public Relations. The opinions and views set forth in this article are those of the writers and are not to be considered as reflecting the policies of the War Department, or the military service at large.

† Ed. Note.—Dr. Paul C. Samson, formerly of Oakland, is on leave of absence from Stanford University School of Medicine (Department of Clinical Surgery). Dr. Leo J Fitzpatrick was in practice in Englewood, New Jersey.

Regardless of how applied strapping is frequently uncomfortable and essentially unphysiologic. Immobilization is never complete nor is the pain always relieved. There is continued compression of the thoracic cage which limits respiratory excursion and pulmonary expansion. This interferes with the efficiency of cough and favors the retention of excess bronchial secretions. As sequelae, atelectasis and pnemonitis occasionally have been observed.

War wounds are always contaminated wounds. Because of this and because many of the injuries are extensive, regional nerve block has been considered more efficient and safer than local infiltration at the injured site. Multiple intercostal injection has been employed most frequently and has been routinely performed at the angles of the ribs. Paravertebral block has been reserved for patients either in whom the intercostal injection was not completely effective, or in whom the wound itself was well mesial to the midscapular line. With paravertebral block both the intercostal nerves and the sympathetic chain are probably infiltrated at the same time. In rare cases of simple fractured ribs, local injection has been used to supplement the other two methods. In planning the injection, wounds and fractured ribs are noted and the area of skin tenderness is outlined. Intercostal or paravertebral infiltration is then performed to include at least two nerves above and two below the painful region. There is no hesitancy in injecting 10 or 11 nerves on one side or in performing bilateral blocks of from five to eight nerves each. In a successful block there is immediate relief from pain and the often dramatic change in the patient's condition will not be soon forgotten. A patient who has been restless, dyspneic and groaning with pain, shortly will be breathing normally and become relaxed and comfortable. Often he will fall asleep within a few minutes.

In nearly all instances the effects of nerve block have lasted for at least 24 hours and, frequently, only one injection has been necessary for permanent relief from pain. This has been a matter for some speculation since the *anesthesia* from injection lasts for only a few hours. Nerve block causes paralysis of the affected intercostal muscles, thereby relieving any associated muscular spasticity. This may be one factor involved in the prolonged effect of the block.

REPORT OF CASES

Case 1.—A 24-year-old soldier received anterior and posterior fractures of the right 5th and 6th ribs in a truck accident in North Africa. The right midthorax was exquisitely tender, and there was paradoxical motion of an area in the axilla, roughly 10 by 5 cm. in extent. Intercostal block of the 3rd through the 8th nerves was performed. Pain and dyspnea were immediately relieved. As respirations became quiet the paradoxical motion completely disappeared and no adhesive stabilization became necessary.

Case 2.—(Case of Major Frank). A 28-year-old sergeant on the Anzio beach-head suffered multiple contusions of the left chest and simple fractures of the 5th through the 11th ribs on that side. There was excruciating thoracic pain unrelieved by morphine; respirations were rapid, shallow, and grunting. Pain was increased by the short haul to a Field Hospital. Intercostal nerve block, D5 through D11, was performed nine hours after injury. There was immediate cessation of pain, and respirations became normal. No further blocks were necessary and the patient was evacuated by air to Naples in complete comfort.

Case 3.—A 27-year-old officer sustained a penetrating shell fragment wound of the right posterior thorax in an advance in France. He was admitted to a Field Hospital eight hours after wounding. A ragged 3 cm. wound was present, with compound, comminuted fractures of the 6th and 7th ribs mesial to their angles. Thoracic wall pain was so intense that the patient could not lie on his back, but was forced to remain prone. Morphine and adhesive strapping had not controlled the pain. With the patient still lying in the prone position, a paravertebral block from the 4th to the 9th nerves was performed. Cessation of pain was almost immediate, and the patient drew his first easy breath in more than eight hours. He could then be turned on his back and shortly thereafter was evacuated in comfort.

COMMENT

Many patients with thoracic injury suffer early respiratory distress and show signs of increased pulmonary moisture. Both fine and coarse rales may be heard over one or both chests. There develops a harassing, painful, wet cough and the patient continues to be unsuccessful in raising the blood and other secretions which flood the bronchial tree. Such is a brief description of what we have designated as the traumatic wet lung syndrome. Proper control of this condition is essential to preserve life and to prepare the patient either for early surgery, or for further evacuation. Tracheobronchial patency depends upon an efficient cough mechanism, and this is most frequently hindered by thoracic pain. Following nerve block, in most instances the patient is able to breathe deeply and to raise sputum effectively. Another possible effect of nerve block is suggested by the work of De Takats[6] who showed that in experimental animals bronchial and bronchiolar spasm followed injury to the thoracic wall. We have considered that the arrest of afferent painful stimuli by nerve injection may play a rôle in releasing the possible spasm. The other methods of treating wet lung are not germane to this paper and have been presented fully elsewhere.[7,8] Frequently, however, nerve block and continued voluntary cough are all the measures necessary to maintain adequate bronchopulmonary drainage.

Case 4.—A 22-year-old private suffered severe contusions of the left chest when a truck overturned in North Africa. There was diffuse tenderness over the left lower chest, but no fractured ribs were demonstrated. The patient had a constant wet cough, and coarse rales were heard throughout the left lung. An intercostal block of the 6th to the 11th nerves was performed. Pain was relieved and the patient commenced to raise sputum with ease. Over a 4-hour period he expectorated 100 cc. of tenacious, bloody secretions and the rales disappeared. Only one nerve block was necessary.

Case 5.—A 27-year-old sergeant received a penetrating gunshot wound of the right chest in Italy. He was admitted to a Field Hospital six hours later, where roentgenograms showed a small right-sided hemothorax, contusion of the lower lobe, and fractures of the 5th and 6th ribs posteriorly. The bullet was buried in the body of the 6th thoracic vertebra. The soldier had an unproductive, painful, wet cough, and was dyspneic. The 4th, 5th, 6th and 7th nerves were injected with only partial success. This was followed by paravertebral block of the same area, which resulted in complete cessation of pain. The cough immediately became productive of large amounts of bloody sputum, and the shortness of breath disappeared. Twenty-four hours later there was another episode of painful unproductive cough, and a second paravertebral nerve block gave complete relief. The patient was then evacuated without incident.

Case 6.—(Case of Major Thomas Burford and Benjamin Burbank). A 25-year-old soldier was in a truck accident in Italy, which resulted in fractures of the left 9th, 10th, and 11th ribs, and a hematoma of the thoracic wall. On entrance to the hospital eight hours after injury, the patient had a painful, wet cough, was dyspneic, and presented numerous fine moist rales bilaterally. The lower six intercostal nerves were blocked on the left and there was immediate and complete disappearance of pain and rales. No further treatment was necessary. Results of this type offer the best proof for the existence of post traumatic bronchial spasm and its cessation following nerve block.

COMMENT

It is essential that pain be relieved following thoracic

operations. A smoother postoperative course is thus insured. The patient will be able to breathe deeply without discomfort, and to expectorate bronchial secretions more effectively. Following operations on the thoracic wall, the location of the incision will dictate whether a regional intercostal, or a paravertebral nerve block may be used to better advantage. When thoracotomy is performed an "internal" infiltration may be carried out, in which an adequate number of intercostal nerves are directly injected through the parietal pleura before the chest is closed.

Nerve block occasionally may help to distinguish between uncomplicated thoracic, and thoraco-abdominal wounds. Abdominal pain, tenderness, and rigidity frequently accompany a low but purely thoracic wound. These signs often disappear following injection of the lower thoracic nerves, and the abdomen becomes soft. When, however, abdominal signs are associated with intraperitoneal pathology, nerve block may be followed by cessation of pain and tenderness, but some involuntary rigidity usually remains.

TECHNIQUE

Intercostal nerve block is best performed with the patient in the lateral recumbent position and the scapula well forward. One per cent procaine solution is employed and five cc. are injected into each nerve. The addition of ten minims of 1-1000 epinephrine hydrochloride to each 100 cc. of procaine apparently prolongs the anesthetic effect. A small wheal is raised over the midpoint of the rib at its angle. The injection needle with bevel faced cephalad is inserted to the rib, then redirected until the point just clears the inferior margin of the same rib. It is then advanced 0.5 cm., and if aspiration is negative for blood, the procaine solution is injected.

Paravertebral injection may be performed with the patient either prone or in the lateral recumbent position. The sites of injection are approximately 4 cm. from the midline and exactly opposite the spinous processes. These points are directly over the transverse processes. A needle at least 8 cm. in length is needed, with a small piece of loose rubber over the shaft to aid in measuring the depth to which the needle is to be inserted. Each needle without the syringe is introduced perpendicularly through an intradermal wheal until the dorsal surface of the transverse process is touched (usually 4 cm.). The small rubber guide is adjusted on the shaft of the needle approximately 3 cm. from the skin surface. With the bevel faced toward the midline, the needle is then slightly withdrawn, redirected anteromedially and passed just below (or above) the transverse process, sliding along the body of the vertebra to the depth indicated by the marker. This places the point of the needle retropleurally in the region of the thoracic ganglia, and injection will usually anesthetize both the sympathetic chain and the intercostal nerve. Prior to infiltration, aspiration is done in two planes to rule out the possibility that the needle has entered the pleural cavity, an extension of the subarachnoid space or a blood vessel. Five cc. of one per cent procaine solution are then injected.

SUMMARY AND CONCLUSIONS

Obliteration of pain is an important step in the treatment of thoracic trauma. Recovery from shock is speeded, obstructing bronchopulmonary secretions are raised more efficiently, and the patient may be transported with greater safety and comfort. Absence of pain following thoracic operations will simplify postoperative care.

It has been emphasized that incapacitating pain may be associated with contusions of the thoracic wall, fractured ribs, and wounds of various types. The rôle of intercostal and paravertebral nerve block in relieving thoracic wall pain of traumatic origin has been described and the techniques of injection have been presented. In treating battle injuries, the reasons for preferring a regional type of block instead of local infiltration have been given. Since nerve block has been employed, thoracic adhesive strapping for the control of pain has been discarded.

Brief case histories have been presented which illustrate the use of nerve block in different situations.

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ACROPARESTHESIA

LYLE SHEPARD, M. D.
Glendale

THE present knowledge of this disease dates back about fifty years to the work of Schultze who in 1892[1] so well described it and gave it its name. Then with the work of Nothnagel we find presented before us two general types in which to divide these cases. The Schultze type in which there are no visible vasomotor symptoms, and the Nothnagel type in which these symptoms are present. Dr. R. Cassirer[2] in reviewing 162 cases estimates that about 25 per cent belong to this latter type.

After reviewing the recent literature and our own cases, it seems proper to consider this latter type an early Raynuad's in harmony with Spiegel[3] and eliminate them from this consideration. Further, this class is relatively rare, and also does not respond well to the same line of treatment as the Schultze type. This latter fact tends to uphold the belief that they belong with Raynuad's disease.

It is appropriate to refresh the mind briefly with the etiology, symptoms, and treatment of this disease before considering a rather typical case specifically.

ETIOLOGY AND SYMPTOMS

Acroparesthesia is the name applied to a sensory disturbance in the extremities, particularly the fingers consisting of sensations of burning, tingling, pricking, stiffness, and especially numbness or the feeling of the member of being asleep. Some writers report pain[4] and pallor but it is very rare in this class. Also the presence of radiculitis[5] is to be doubted. Putman[6] explained that these sensations are due to a decrease of blood flow in the extremities following a constriction of the arteriols which in turn is due to increase tonus of the Vegetative

nervous system. There are two or more salient facts that tend to substantiate this as the leading cause.

1. The condition is worse the first thing in the morning and in cold weather or when the extremities are chilled. With the relaxation of the body organism at night, there is a dilatation of the blood vessels with a cessation of symptoms which return upon arising in the morning because of the constricting of these vessels as mentioned above.

2. Acroparesthesia is found chiefly in women during the climacteric at which time there is an imbalance of the endocrine glandular system which in turn has an influence on the Vegetative nervous system and thus influences the flow of blood.

Sinkler[7] goes further and states that he thinks that it is due to faulty circulation of blood in the peripheral nerve fibers themselves.

TREATMENT

The treatments suggested are legion which would lead one to believe that there is no successful remedy, especially when some improve without any treatment, when in reality there are several good remedies to chose from. Any anemia or avitaminosis should of course be corrected. Following are listed five remedies of known value. 1. Estrogenic hormone if patient is in the climacterie. Ten thousand units weekly is usually sufficient. 2. Hot and cold contrast baths to the afflicted extremities. These are conducted by immersing the limbs alternately in hot and cold water, first in water as hot as can be borne for three minutes, then one-half minute in real cold water. This treatment should be continued for twenty to thirty minutes once or twice daily. 3. Diathermy to the limbs. A good combination is to use the contrast baths one time daily and the diathermy one time daily. On the whole the contrast baths have proven more satisfactory than the diathermy because they tend to bring about a more healthy condition of the skin. 4. Niacin in amounts ranging from 50 to 100 milligrams three times daily. 5. Acetylcholine.

REPORT OF CASE

CASE 1.—This patient came into my office two years ago complaining of numbness and tingling of the hands and feet ("pins and needles") which had bothered her for six months. The condition was worse in the morning usually clearing up in two or three hours but sometimes lasted until noon. She had never had anything like it before and there was nothing in her history that pointed to a cause. The family was financially secure so the patient did only part of her own house work. She had been taking estrogenic hormone for several weeks because she had shown symptoms of the climacteric.

Physical Examination. The patient was a well developed white female of 45 who did not appear acutely ill, and was intelligent and coöperative. The examination showed no pathology in nose, throat, chest, or heart. Blood pressure was 135/80, pulse 76 and of good quality. The abdomen was normal and there was no abnormal pelvic condition.

Laboratory Tests. Urine was normal. Blood count showed no deficiencies. Hemoglobin 92 per cent, Red blood count 4,920,000, White blood count 6,400, Differential normal, Sedimentation rate within normal range.

Treatment. 1. Contrast baths daily. 2. Estrogenic hormone continued at 10,000 units weekly. 3. Niacin, 100 mgm. three times daily. This was reduced in three days to 50 mgm. three times daily because the patient complained of flushing. 4. Acetylcholine, 0.10 Gm. intramuscular three times weekly.

This patient felt improvement from the first treatment, which gradually continued until all symptoms cleared up. The treatment was continued for two weeks. After two weeks the acetylcholine injections were reduced to one weekly. The symptoms left completely after eight weeks of treatments and have not returned since. The patient has since sought to maintain a good tone to her skin by proper measures.

COMMENT

This case was different than the average in that the condition was present in the feet as well as the hands. Although it was quite evident that this was a case of the socalled menopausal acroparethesia, the trouble did not clear up with the use of estrogenic hormone alone. Again this patient did not belong to the working class as emphasized by Straus and Guttmann.[8] Further there was no reduction of strength such as noted by Ekbom.[9]

DIAGNOSIS

While it is not the purpose of this paper to discuss conditions that can be confused with acroparethesia, it might be of value to name a few such as types of neurosis, peripheral nerve diseases as neuritis, spinal cord conditions as tabes, syringomyelia and disseminated selerosis, endocrine disorders as tetany and acromegaly, or intoxications such as caused by ergotism.

SUMMARY

1. Acroparethesia is thought to be an entity distinct from cases of similar symptoms which show visible vasomotor symptoms. 2. In the majority of cases very simple methods of treatment suffice to clear up the trouble, even Swedish massage will many times turn the trick in mild cases.

1509 East Wilson Avenue.

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Nicolò Paganini (1782-1840).—The genius of Paganini was ever a delight to composer, performer and listener alike. Harsh parental treatment in childhood planted the seeds for his life-long precarious health which finally ended in tubereulosis of the lungs and larynx. At 52, he was a doomed man. One May evening, aroused as out of a lethargy, he took his violin and played before a portrait of Byron, whom he much admired. Suddenly, the violin and bow fell from his hands, he fainted, and the next morning was dead.—Warner's *Calendar of Medical History.*

Rufus of Ephesus, who lived in the reign of Trajan (98-117), gave the first description of traumatic erysipelas, epithelioma and bubonic plague.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-third (323rd) Meeting of the Council of the California Medical Association

The meeting was called to order in the Green Room of the Hotel Fairmont, in San Francisco, at 10:00 A.M., on Sunday, February 25, 1945.

1. Roll Call:

Present: Councilors Philip K. Gilman, Chairman; Lowell S. Goin, Karl L. Schaupp, E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Sidney J. Shipman, Herbert A. Johnston, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Present by Invitation: L. A. Alesen, M.D., Vice-Speaker; Dwight H. Murray, M.D., Chairman Committee on Public Policy and Legislation; T. Henshaw Kelly, M.D., C.P.S. Trustee; John Hunton, Executive Secretary; A. E. Larsen, M.D., Medical Director, C.P.S.; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; Clem Whitaker, Public Relations Counsel; Ben Read, Secretary California Public Health League; W. Glenn Ebersole; H. J. Templeton, M.D., Alameda County; Rollen Waterson of Gary, Indiana; H. Clifford Loos, M.D., Los Angeles; and Sidney N. Parkinson, M.D., Alameda County.

2. Minutes:

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (322nd) held in Los Angeles on January 4, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, for April, page 179.)

(b) Executive Committee meeting (188th) held in Los Angeles, January 5, 1945.

(c) Executive Committee meeting (189th) held in San Francisco, January 21, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, for February, page 62.)

(d) Executive Committee meeting (190th) held in San Francisco, January 31, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, for March, page 122.)

3. Membership:

(a) A report of the membership, as of February 24, 1945, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1945: 5,877.

Total members in military service: 2,170.

(b) The question of membership with dues waived for members serving with the United States Public Health Service was brought up for discussion. On motion

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

made and seconded, it was voted that dues of such members be waived for the Duration.

(c) On motion made and seconded, Retired Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Lillian Shields, Alameda County
J. David Beatty, Los Angeles County
Guy L. Bliss, Los Angeles County
E. C. Kellogg, Los Angeles County
B. A. McBurney, Los Angeles
Newton M. Otis, Los Angeles County
Thomas E. Bailly, San Francisco
George R. Carson, San Francisco County
H. B. Graham, San Francisco County
William J. Haber, San Francisco County
Arthur P. Kaelber, San Francisco County
John Dysart Dameron, San Joaquin County
Norman E. Williamson, San Joaquin County

(d) On motion made and seconded, Associate Membership was granted to Charles W. Duvall, Santa Clara County, whose application had been received in accredited form from his county society.

4. **Financial:**

(a) A cash report as of February 24, 1945, was submitted.

(b) Report was made concerning income and expenditures for January and for one month, ended January 31, 1945.

(c) A balance sheet, as of January 31, 1945, was submitted.

On motion made and seconded, the above reports were received and placed on file.

(d) Concerning the budget for year 1946, submitted by the Auditing Committee and the Executive Committee, it was agreed that the same should be resubmitted for action at the Council meeting to be held prior to the Annual Session.

5. **Interim Appointments:**

Council Chairman Gilman reported upon tentative appointments made since the last Council meeting held on May 4, 1945.

On motion made and seconded, it was voted that the appointments, which follow, be confirmed:

(a) Frank A. MacDonald, Sacramento, appointed as Liaison Contact with California Veterans Committee.

(b) James B. Irwin, San Diego, appointed Secretary to C.M.A. Section on Radiology, vice Beth T. Pinkston, resigned because of illness.

(c) George H. Evans, San Francisco, appointed to Advisory Board of C.M.A. Committee on History.

(d) Wilson Stegeman, Santa Rosa, appointed to Advisory Committee to C.M.A. Committee on Public Policy and Legislation.

6. **On Publication of Minutes of the Special Session of the C.M.A. House of Delegates:**

(a) The Council reconsidered its former action (Item 13(b) in minutes of the 322nd meeting), concerning the publication of the full minutes of proceedings of the Special Session of the House of Delegates held in Los Angeles January 4-5-6, 1945.

The typewritten transcript covers some 460 pages. Because the resolutions and other important comment concerning the Special Session and subsequent actions bearing thereon had appeared in California and Western Medicine, and in special letters and bulletins sent out by the central office, the Council deemed it unwise to appropriate some $3,500 for printing and distributing the complete minutes, since the official copies are on file in the central office of the Association.

On motion made and seconded, it was voted not to print the complete minutes.

(b) Report was made on the conference held at the Sutter Club in Sacramento on Thursday, January 25, 1945, the same having been arranged to comply with the action of the House of Delegates in its resolution as printed in California and Western Medicine, for January, 1945, on page 34.

(For additional information concerning the conference held in Sacramento, see California and Western Medicine, for February XLVI, on page 83.)

It was agreed that a similar conference should be held, if deemed advisable, some time in March, preferably in Sacramento, the call and arrangements therefor to be made by the Chairman of the Committee on Public Policy and Legislation, Dr. Dwight H. Murray.

7. **Proposed California Sickness Insurance Laws:**

The Council then took up the discussion of the major sickness insurance legislation that had been submitted to the 56th California Legislature now in session. The proposed laws receiving special discussion were:

1. Assembly Bill 449, sponsored by the C.I.O.;
2. Assembly Bill 800, sponsored by Governor Earl Warren;
3. Assembly Bill 1200, sponsored by the California Medical Association;
4. Assembly Bill 1414, a bill identical with the measure proposed several years ago by former Governor Olsen.

Reports were made by Dwight H. Murray, Chairman of the C.M.A. Committee on Public Policy and Legislation; Mr. Ben Read, Secretary of the California Public Health League; and Mr. Clem Whitaker, Public Relations Counsel. Questions were asked and discussions participated in by members of the Council.

Mention was made that digests of these and related bills were outlined in California and Western Medicine, for February, on pages 89-92.

Dr. Murray, Mr. Read, and Mr. Whitaker informed the Council concerning their impressions on the attitude of individual State Senators and Assemblymen concerning the proposed legislation.

They stated that prior to the constitutional recess of the Legislature on January 26th, the general sentiment of Legislators as expressed, did not indicate that the compulsory insurance bills would go on to passage in both Houses of the Legislature during the present session.

Discussion was also had concerning the possibility of an appeal by one or more of the proponent groups through resort to initiative that would be placed on the ballot of the general election in November, 1946.

Discussion followed concerning the work that had been done thus far. It was voted to be the opinion of the Council that voluntary insurance was preferable to the compulsory plans that had been submitted. The Officers of the Association were commended for the presentation of the statement that they had made concerning the attitude of the Association and thanks were given to the Legislative Committee and Legal Department for their efficient service.

The courtesy of the floor was extended to Dr. Clifford Loos of Los Angeles who called attention to some phases of the proposed legislation which he deemed important. Dr. Loos submitted a list of currently operated medical plans in California, this report being placed on file.

Dr. H. J. Templeton, President of the Alameda County Medical Association, spoke on types of prepayment plans with special reference to indemnity instead of fee-for-service.

8. **California Physicians' Service:**

Report was made concerning an extension in the public relations work of California Physicians' Service.

Motion was made to allocate $2,000 per month for a period of 12 months to carry on this work. The motion was not carried. It was then voted to authorize the C.M.A. Executive Committee to have power to act on this request.

9. **Hospitalization Work (Liaison Committee on Blue Cross Hospitalization Groups in California):**

Discussion was had on ways and means of extending hospitalization coverage, and it was agreed that conferences should be held with the hospitalization groups and an effort made to have hospitalization coverage available to individual citizens.

10. **1945 Annual Session:**

(a) A memorandum report was submitted concerning the rules of the Office of Defense Transportation limiting convention travel to 50 persons or less. The plan of representation in the House of Delegates received informal comment.

(b) Memorandum report was also submitted concerning the program outlined by the C.M.A. Committee on Scientific Work for the Scientific Sessions, meetings to be held in coöperation with the Los Angeles County Medical Association. (Details concerning the plans appear in California and Western Medicine, for February, on page 97; and for March, pages 106 and 137.)

(c) Concerning Resolution No. 1, adopted by the C.M.A. House of Delegates at the 1944 Annual Session (California and Western Medicine, June, 1944, page 307), the Council agreed it was not advisable to institute such prizes and awards at this year's streamlined session.

11. **Woman's Auxiliary:**

The recommendations of the Woman's Auxiliary to the California Medical Association concerning this year's Annual Session were submitted and it was agreed that the plan outlined by the Officers of the Woman's Auxiliary, not to hold a State meeting, be approved.

12. **Legal Department:**

General Counsel Hartley F. Peart reported on the following matters:

(a) *I.A.C.—Fee Schedule:* The general counsel stated that pursuant to previous authorization of the Council, Assembly Bill 7102 had been drafted and thereafter introduced by Assemblyman King of Oroville. This bill expressly gives the Industrial Accident Commission power, which it now has by implication, of fixing a fee schedule in compensation cases. The bill provides that this fee schedule must be reviewed by the Commission once in every two years. The bill prohibits any physician to rebate on his fees, and provides that any agreement made by an insurance company or employer for medical service must provide for reasonable fees and is of no force or effect unless filed with the Commission. Mr Peart stated that for practical reasons the bill did not include other desirable amendments and that these amendments had the approval of the Commission itself, acting through Commissioner Garrison.

(b) *Administrative Agencies—Procedure, Hearing Officers:* General Counsel Peart further reported that the Judicial Council of California had developed a code of administrative procedure dealing with proceedings before various boards and commissions, including the State Board of Medical Examiners, and that legislation to carry this report into effect had been introduced. The general counsel stated that the State Board of Medical Examiners under this act would have the benefit of the services of a hearing officer who must be an attorney at law of five years' experience, who would deal with questions of procedure on hearings before the Board; further, that proceedings for judicial review of the actions of the Board were clarified and regulated under another portion of the Council's report.

(c) *California Physicians' Service—Decision of District Court of Appeal:* General Counsel Peart stated that on January 15th, the District Court of Appeal of the Second Division, composed of presiding Justice Nourse, Associate Justice Sturtivant, and Justice Pro Tem Dooling, had unanimously affirmed the decision of Superior Judge Goodell holding that California Physicians' Service is a nonprofit service corporation and not an insurance company; that California Physicians' Service is not unlawfully engaged in the corporate practice of medicine; that while its prepaid medical service provides for a distribution of the risk, it does not in any sense indemnify patients or insure their health, but on the contrary renders service to them in the event of sickness or accident.

The general counsel was instructed to mail a copy of the decision to each member of the Council.

Mr. Hassard then reported on the present status of the California Medical Association's voluntary bill (A.B. 1200). He stated that several different groups had requested amendments to the bill. These requests were discussed in detail by the Council, and after motion duly made and seconded, it was decided to leave all matters relating to A. B. 1200 in the hands of the Committee on Public Policy and Legislation.

13. **Association of American Physicians and Surgeons:**

Mr. Rollen W. Waterson, of Gary, Indiana, Secretary of the Association of American Physicians and Surgeons, was introduced. Members of the Council were invited to attend a meeting of the Alameda County Medical Association on Monday, February 26th, at which time Mr. Waterson would give an address on the work of the A.A.P.S.

14. **California Association of Medical Laboratory Technicians:**

The Council recommended to the Committee on Public Policy and Legislation that it take steps to oppose the enactment of Senator Parkman's S. B. 175.

15. **Time and Place of Next Meeting:**

(a) It was agreed that the next meeting should be held at 12:30 noon on Saturday, May 5, 1945, in Los Angeles.

(b) It was agreed that C.M.A. delegates to the A.M.A. House of Delegates should be invited to attend the meeting of the Council on Saturday, May 5th.

16. **Executive Session:**

The Council went into Executive Session to consider ways and means of combating proposed sickness insurance legislation.

17. **Adjournment.**

Philip K. Gilman, M.D., *Chairman,*
George H. Kress, M.D., *Secretary.*

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION*

Minutes of the One Hundred Ninety-first (191st) Meeting of the Executive Committee of the California Medical Association

The meeting was called to order in the office of the Association, 450 Sutter Building, San Francisco, at 10:00 A.M., on Sunday, April 8, 1945.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

1. **Roll Call:**

Members Present: John W. Cline, Chairman; E. Vincent Askey, Speaker of House of Delegates; Karl L. Schaupp, Past-President; Philip K. Gilman, Council Chairman and President-Elect; and George H. Kress, Secretary.

Members Absent: Lowell S. Goin, President.

Present by Invitation: Lloyd Kindall, Councilor; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; John Hunton, Executive Secretary; Clem Whitaker, Public Relations Counsel; Ben Read, Secretary Public Health League of California; W. Glenn Ebersole; and W. M. Bowman of California Physicians' Service.

2. **Minutes:**

On motion made and seconded, the minutes of the 190th meeting of the Executive Committee, held in San Francisco on January 31, 1945, were approved. (Minutes were printed in California and Western Medicine, for March, on page 122.)

3. **Sickness Insurance Legislation:**

Reports were received concerning sickness insurance bills presented to the 56th California Legislature, now in session in Sacramento. (The C.M.A. bill, A B. 1200, appeared in California and Western Medicine, for February, on page 65; and digests of Governor Earl Warren's bill, A.B. 800, and the C.I O. bill, A B. 449, and other bills, appeared in the same issue on pages 89-92.)

Extensive reports were presented to the Executive Committee by Mr. Ben Read, Secretary of the Public Health League of California; and Mr. Clem Whitaker, Public Relations Counsel. Supplementary reports were made by Mr Hartley F. Peart, Legal Counsel, Mr. Howard Hassard Associate Legal Counsel; and Mr. John Hunton, Executive Secretary.

The speakers explained what had taken place in the various hearings of the Assembly Committee on Public Health, and the general reaction of Legislators to the subject of compulsory sickness insurance.

It was stated that the Assemb'y Committee on Public Health had voted to not send out the bills to the Assembly floor but efforts were being made by Administration and C I O. groups to secure the 41 votes necessary to bring the measures before the Assembly, during the week of April 9th.

Informal comment concerned possible future plans of proponents of compulsory sickness legislation Mention was made of legislation that might lead to the appointment of interim study committees, either of the Assembly or a joint Senate-Assembly Committee. Possible referendum and initiatives also were mentioned.

The reports submitted indicated, even though the Assembly Committee on Public Health had refused to approve Governor Warren's Compulsory Health Bill, A.B. 800, and the C.I.O. Bill, A.B. 449, that the supporters of those measures were continuing active work to bring the issues to vote either in the Legislature or possibly at special or regular State election.

Informal discussion took place on best ways and means of meeting some of these issues, should occasions arise.

Members of the Committee and invited guests took part in the discussions. Speaker E. Vincent Askey presented a special report outlining plans he had taken up with colleagues in Southern California. It was agreed that some of the items that had been submitted should be gotten into form for possible presentation to the Council and House of Delegates, at Los Angeles on May 6-7, 1945.

4. **Miscellaneous Legislation:**

Associate Legal Counsel Howard Hassard made informal comment concerning a number of other bills related to the public health and healing art practice in which members of the profession have a natural interest. It was felt that for the time being, no immediate action would be necessary thereon.

5. **Committee on History:**

The C.M.A. Committee on History, through Chairman Morton R. Gibbons, requested permission to hire casual clerical aid in order that archives and other informative material from colleagues in military service could be secured. It was agreed that this should be done.

6. **Woman's Auxiliary:**

(a) A letter from the President of the Woman's Auxiliary to the C.M.A., Mrs. Ralph Eusden, dated April 2nd, was read. The Executive Committee concurred in the recommendation that the Auxiliary Officers should continue as such for the coming year and until the next general State Meeting is held by the Auxiliary.

(b) Concerning entertainment features in Los Angeles during the coming Annual Session, it was believed, owing to the limited number of delegates who would be in attendance, and because of announcmeents made to conform with the directives of the Office of Defense Transportation, it would not be advisable to arrange for entertainment features in Los Angeles on May 6-7.

7. **Taxation of X-Ray Films:**

General Counsel Peart reported that the State Board of Equalization had adopted a new rule purporting to impose a sales tax on x-ray film as distinct from the professional opinion of the doctor. He stated that he had held an extended telephone interview with President Goin on the subject and that Dr. Goin had requested that the matter be brought before the Committee.

After discussion, Mr. Peart was instructed to take up this matter with the State Board of Equalization and endeavor to obtain a ruling that no sales tax should be or can be legally levied upon the use made of film in connection with professional services.

8. **Annual Session in Los Angeles:**

Informative material concerning the Annual Session to be held in Los Angeles on May 6-7, 1945, having been sent to members of the Council, it was agreed that the plans submitted should be carried through. Scientific Sections would hold their meetings under the local auspices of the Los Angeles County Medical Association.

9. **Proposed Amendments to C.M.A. Constitution:**

A letter from Councilor Donald Cass concerning changes in the Constitution whereby the Vice-Speaker of the House of Delegates and the Chairman of the Committee on Public Policy and Legislation should become voting members of the Council, received informal discussion.

It was stated that the Chairman of the Committee on Public Policy and Legislation, Dr. Dwight H. Murray, felt that such a provision would handicap him in his work.

10. **C.P.S. and Indemnity Payments:**

Councilor Lloyd Kindall of Oakland, spoke concerning a letter he had submitted under date of March 22nd in which the following question was put:

"Shall the Council of the California Medical Association recommend to the Administrative Members of the California Physicians' Service that California Physicians' Service be changed so that fees for medical services be paid direct to the patient and not to the Doctor?"

It was agreed that the item should be placed on the agenda of the Council meeting for further consideration.

11. **Committee on Postwar Plans:**

Council Chairman Gilman spoke concerning a plan of

procedure in connection with postwar activities with special relation to facilities of military colleagues who were returning to practice in California. He stated he had appointed such a committee as follows:

John W. Cline, M.D., San Francisco, California Medical Association.

Philip K. Gilman, M.D., San Francisco, California Medical Association.

Anthony B. Diepenbrock, M.D., San Francisco, State Board of Medical Examiners.

Frank W. Otto, M.D., Los Angeles, State Board of Medical Examiners.

L. R. Chandler, M.D., San Francisco, Stanford University School of Medicine.

B. O. Raulston, M.D., Los Angeles, University of Southern California School of Medicine.

Wilton L. Halverson, M.D., San Francisco and Los Angeles, State Board of Public Health.

Phoebus Berman, M.D., Los Angeles, Los Angeles County Hospital.

Benjamin W. Black, M.D., Oakland, Alameda County Hospital.

Harold A. Fletcher, M.D., San Francisco, Procurement and Assignment Service.

John Hunton (ex-officio), San Francisco, Secretary.

The Executive Committee approved the appointment of the committee.

12. California State Board of Public Health:

President-Elect Gilman stated that he had had a conference with Director of Public Health Wilton L. Halverson, concerning the establishment of blood banks, with special reference to proposed legislation thereon.

Chairman Cline pointed out that the San Francisco County Medical Society had opposed the institution of such blood banks unless certain safeguards were provided.

It was stated that Chairman Murray of the Committee on Public Policy and Legislation had learned that there is considerable objection in the Legislature toward compulsory provisions in the contemplated bills.

Dr. Gilman said he would inform Director Halverson concerning the objections that had been brought forward.

13. Adoption Laws in California:

Report was made that Director C. W. Wollenberg of the State Department of Social Welfare wished to appoint a committee consisting of three members of the State Bar, three members of the California Medical Association, and three members of the State Government to make a study of the adoption laws of California.

Dr. Gilman stated that upon request of Director Wollenberg, he had appointed to represent the C.M.A.: Philip K. Gilman, San Francisco; Donald G. Tollefson, Los Angeles; and George H. Kress, San Francisco.

The Executive Committee approved the action taken.

14. Coordinating Committee of California Procurement and Assignment Service:

A letter of March 13th, concerning a resolution regarding Class 1 and Class 2 nurses received from Chairman Harold A. Fletcher, was presented. No action was taken thereon.

15. Proposed Letter to County Society Officers:

A letter dated March 2nd, received from J. Frank Doughty, M.D., of Tracy, Chairman of the Committee on Membership was read. The letter had to do with cooperation with military colleagues returning to civilian practice.

It was agreed that the letter should be turned over to the newly appointed Committee on Postwar Plans for Military Colleagues.

16. Adjournment:

There being no other business, the meeting adjourned at 6:00 P.M.

JOHN W. CLINE, M.D., *Chairman,*
GEORGE H. KRESS, M.D., *Secretary.*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (76)

Alameda County (6)

Bjorklund, J. Harman, *Livermore*
Cull, Virginia L., *Oakland*
Levine, H. S., *Oakland*
Pillsbury, Ruth M., *Oakland*
Schnoor, Thomas G., *Berkeley*
Woods, Walter L., Jr., *Oakland*

Butte-Glenn County (1)

Baty, Fred D., *Kansas City, Missouri*

Contra Costa County (1)

Kaess, James B., *Brentwood*

Fresno County (2)

Seibel, John J., *Reedley*
Sinay, Henry, *Fresno*

Imperial County (1)

Kortheuer, Karl H., *Calexico*

Los Angeles County (33)

Beddoe, Paul, *Long Beach*
Bross, Rachel B., *Los Angeles*
Brown, J. Scott, *Long Beach*
Bell, Leslie M., *Pasadena*
Church, Burt Thomas, *North Hollywood*
Cooley, Mahlon Cecil, *Los Angeles*
Crawford, Alanith V., *Santa Monica*
Dublin, William Brooks, *Los Angeles*
Engle, Robert B., *Pasadena*
Fareed, Omar John, *Glendale*
Ferman, Jack A., *Long Beach*
Francis, J. Donald, *Los Angeles*
Frank, William P., *Alhambra*
Friedgood, Harry B., *Los Angeles*
Frudenfeld, Karl, *Inglewood*
Fuchs, Arthur Robert, *Long Beach*
Gairdner, Thomas M., *Burbank*
Hansen, Louis O., *Compton*
Hoagland, Paul Ingalls, *Pasadena*
Kahlstrom, Carl Ewald, *Long Beach*
Levinthal, Daniel H., *Beverly Hills*
Margarian, Sennacherib M., *Long Beach*
Morgenroth, Frank C., *Los Angeles*
Morrow, James Joseph, *Burbank*
Pearl, Sarah A., *Beverly Hills*
Rosenbloom, Davis, *Los Angeles*
Rothman, Theodore, *Los Angeles*
Sevener, Clinton J., *Los Angeles*
Simpson, William Edward, Jr., *North Hollywood*
Soudakoff, Peter S., *Los Angeles*
Sparkuhl, Konstantin, *Los Angeles*
Stratton, Victor Charles, *Los Angeles*
Wallner, Adolf, *Los Angeles*

Marin County (1)

Oliva, George, *San Anselmo*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Merced County (1)

Hillyer, L. R., *Los Banos*

Monterey County (1)

Corp. Keith, *Salinas*

Napa County (2)

Peterson, Walter W., *Napa*

Sandness, J. E., *Napa*

Riverside County (2)

Gill, Arthur F., *Banning*

Lauter, Monte A., *India*

San Bernardino County (1)

Campbell, Guy Gibson, *Addis Ababa, Ethiopia*

San Francisca County (12)

Crowe, John A., *San Francisca*

Farber, Jason E., *San Francisca*

Fishman, Victor Paul, *San Francisco*

Gilmore, Edith Schrader, *San Francisca*

Guadagni, Albert Paul, *San Francisco*

Henry, Margaret, *San Francisca*

Larsen, Leonard H., *San Francisca*

Newman, Thomas R., *San Francisca*

Perez, Eugene Reyes, *San Luis Obispa*

Richards, Victor, *San Francisco*

Tuschka, Otto Joseph, *San Francisca*

Tyler, Ynez Coit, *San Francisca*

San Joaquin County (2)

Hill, W. Theodore, *Stockton*

Michals, N. J., *Ladi*

San Matea County (1)

Wertheim, Morris, *Sauth San Francisco*

Santa Barbara County (6)

Brown, Louise P., *Santa Barbara*

Feld, David D., *Santa Barbara*

Hyatt, Herbert, *Santa Barbara*

Jennings, W. Kenneth, *Santa Barbara*

Murdock, Edgar Paul, *Guadalupe*

Tirico, Joseph G., *Santa Barbara*

Shasta Caunty (1)

Mayers, Howard Doane, *Fall River Mills*

Tulare County (1)

Craycroft, Robert N., *Tulare*

Ventura Caunty (1)

Howarth, E. M., *Santa Paula*

Transfers (14)

Bowles, Doris Emerson, from *San Francisca Caunty* to *Alameda Caunty.*

Crandall, Frank G., Jr., from *Stanislaus Caunty* to *Las Angeles Caunty.*

Crites, A. H., from *San Bernardino Caunty* to *Ventura Caunty.*

Custer, William Castleberry, from *Las Angeles Caunty* to *Alameda County.*

Drake, Howard H., from *Orange Caunty* to *Las Angeles County.*

Gardinier, William H., from *San Francisco Caunty* to *Las Angeles Caunty.*

Janzen, Jacob, from *San Bernardina Caunty* to *Las Angeles County.*

Kirkpatrick, John E., from *Shasta Caunty* to *San Francisco County.*

Larson, S. A., from *Contra Casta County* to *Salana County.*

McKee, Wayne P., from *Stanislaus County* to *Humbaldt County.*

Mraz, Gerald L., from *Kings County* to *San Bernardino County.*

Saunders, William W., from *Contra Casta County* to *Alameda County.*

Von Saltza, John, from *San Francisca Caunty* to *Santa Clara Caunty.*

White, Henry Lawrence, from *Shasta Caunty* to *Las Angeles Caunty.*

Resignations (1)

Hume, Portia Bell, *San Francisca Caunty.*

In Memoriam

Abbot, Frank Farnum. Died at Ontario, March 9, 1945, age 61. Graduate of the Jefferson Medical College of Philadelphia, Pennsylvania, 1907. Licensed in California in 1907. Doctor Abbot was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Bruin, Mackall R. Died at Los Angeles, March 10, 1945, age 78. Graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1895. Licensed in California in 1910. Doctor Bruin was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Cooder, Howard Russell. Died at Los Angeles, March 26, 1945, age 58. Graduate of McGill University Faculty of Medicine, Montreal, 1921. Licensed in California in 1924. Doctor Cooder was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Cunningham, Thomas Maltby. Died at La Mesa, February 26, 1945, age 76. Graduate of Columbia University College of Physicians and Surgeons, New York, 1895. Licensed in California in 1921. Doctor Cunningham was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Hodgins, Frederick William. Died at Oakland, April 6, 1945, age 71. Graduate of the University of Toronto Faculty of Medicine, Ontario, 1896. Licensed in California in 1902. Doctor Hodgins was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Kohls, Clara Lydia. Died at San Francisco, March 18, 1945, age 49. Graduate of the University of California Medical School, Berkeley-San Francisco, 1927. Licensed in California in 1927. Doctor Kohls was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Monteith, Robert Fisher. Died at Redwood City, April 10, 1945, age 43. Graduate of Rush Medical College, Illinois, 1930. Licensed in California in 1930. Doc-

tor Monteith was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Shields, Lillian. Died at Piedmont, March 22, 1945, age 71. Graduate of the Cooper Medical College, San Francisco, 1902. Licensed in California in 1902. Doctor Shields was a Retired member of the Alameda County Medical Assocaition, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

COMMITTEE ON SCIENTIFIC WORK

74th Annual Session

Los Angeles, May 6-7, 1945

COMMITTEE ON SCIENTIFIC WORK
Executive Group
George H. Kress, Chairman, ex-officio
Howard F. West, 1945 Fletcher B. Taylor, 1946
J. Homer Woolsey, 1947
Salvatore P. Lucia, ex-officio (for Medicine)
Leon Goldman, Ex-officio (for Surgery)

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SCIENTIFIC ASSEMBLIES

* * *

GENERAL AND SECTION MEETINGS

* * *

FIRST GENERAL MEETING

Sunday Morning, May 6, 1945, at 10:00 a.m.
Lodge Room (Elks Temple)

Presiding
KARL L. SCHAUPP, *Past President*
LOWELL S. GOIN, *President*

Invocation

(1)
Address of Welcome—Jay J. Crane, M.D., President of the Los Angeles County Medical Association.

(2)
Greetings from the Woman's Auxiliary—Mrs. Ralph Eusden, President of the Woman's Auxiliary to the California Medical Association.

(3)
Address of President—"The Philosophical Background of Compulsory Health Insurance"—Lowell S. Goin, M.D., Los Angeles, President of the California Medical Association.

(4)
The Profession's Postwar Responsibilities to Colleagues in Military Service—Philip K. Gilman, M.D., President-Elect of the California Medical Association.

(5)
California Department of Public Health—Wilton L. Halverson, M.D., Director of Public Health, State of California.

(6)
Board of Medical Examiners of State of California—Frederick N. Scatena, M.D., Secretary of the Board.

(7)
Report of Committee on Public Policy and Legislation—Dwight H. Murray, M.D., Napa, Chairman.

(8)
Treatment of Rheumatic Fever—Lt. Comdr. George C. Griffith, (MC), U.S.N.R., U. S. Naval Hospital, Corona. Chairman of War-Time Graduate Medical Meetings Committee for 24th Zone, (Southern California). (With slides.)

* * *

I
GENERAL MEDICINE SECTION

Meeting Room: Lodge Room (Elks Temple)

JOHN MARTIN ASKEY, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

SALVATORE P. LUCIA, M.D., *Secretary*
2898 Broadway, San Francisco

HOWARD DENNIS, M.D., *Assistant Secretary*
9615 Brighton Way, Beverly Hills

Sunday, May 6, 2:00 p.m.
JOINT MEETING WITH SECTION ON SURGERY

Paper No. 9:

Chairman's Address—Some Thoughts on the Need for a Central Medical Registry—John Martin Askey, M.D., 1930 Wilshire Boulevard, Los Angeles.

Truth in medicine depends upon an elaborate accumulation of facts carefully observed, carefully collated, and carefully analyzed. Truth in the past has suffered because of the inability to collect the facts resident in the clinical experience of the great body of medical practitioners. This is a plea for an attempt to utilize these experiences.

PART I—PANEL DISCUSSION OF DISEASES OF THE LIVER

Paper No. 10:

The Gallbladder and Diseases of the Liver—William C. Boeck, M.D., 2210 West Third Street, Los Angeles.

The rôle of the gallbladder in the production of diseases of the liver is strictly a very limited one. Chronic cholecystitis alone or associated with cholelithiasis produces no diseases of the liver, but the complication of perforation in acute cholecystitis with abscess formation may involve the liver. Malignant tumors of the gallbladder likewise produce liver involvement by metastasis.

Paper No. 11:

Infections of the Liver with Special Reference to Amebiasis—L. A. Alesen, M.D., 1401 South Hope Street, Los Angeles.

Amebic hepatitis and amebic abscess of the liver can be expected to occur more frequently in future practice as a result of military operations in the tropics. Awareness of amebiasis as a factor in the production of abdominal symptoms is stressed. Its complications in the form of hepatitis and abscess should be borne in mind in the diagnosis of obscure abdominal lesions. Diagnostic points are presented and the differential features between pyogenic and amebic infections of the liver are emphasized. Treatment of uncomplicated amebic liver abscess by emetine and aspiration is outlined. Dangers and complications are discussed. The management of secondarily infected abscesses of extra-serous drainage and the administration of sulfonamids and/or penicillin is discussed.

Paper No. 12:

Cirrhosis of the Liver—Captain A. M. Snell. (MC), U.S.N.R., U. S. Naval Hospital, Oakland.

Increasing knowledge of dietetic and other factors influencing regeneration repair of liver tissue has provided a stimulus for new methods of treatment of cirrhosis. The diagnosis and therapy of the disease will be discussed in the light of some of these recent physiological conceptions. (With slides.)

Paper No. 13:

The Status of the Liver and Its Importance to the Surgeon—Philip J. Cunnane, M.D., 1052 West Sixth Street, Los Angeles.

Estimate of the degree of hepatic damage with clinical tests is not reliable. Functions of the liver are multiple. A remnant of normal hepatic parenchyma readily compensates for the whole. Liver damage, secondary to surgical disease, is usual and often unmeasurable. It should be recognized and treated as a complicating sequence.

Paper No. 14:

Chairman's Address—The Treatment of Cardiospasm by Esophago-gastrostomy—H. Glenn Bell, M.D., University of California Hospital, San Francisco.

Caridospasm is a term frequently used to describe the syndrome in those patients who have more or less characteristic symptoms of dysphagia, regurgitation, and epigastric pain of long duration. This is a report of nine patients treated by esophago-gastrostomy.

PART II—PANEL DISCUSSION ON VASCULAR DISEASES

Paper No. 15:

Recent Contributions to the Abnormal Physiology and Treatment of Hypertension—Myron Prinzmetal, M.D., 2007 Wilshire Boulevard, Los Angeles.

A brief discussion of recent contributions to the physiological disturbances in hypertension will be presented. The effect of kidney extracts, renin, tyrosinase, proteose solutions, thiocyanate, and other substances claimed to be useful in hypertension will be discussed.

Paper No. 16:

The Surgical Treatment of Hypertension—Howard C. Naffziger, M.D., and Francis L. Chamberlain, M.D., University of California Hospital, San Francisco.

The results of twelve years of surgical treatment of hypertension at the University of California Hospital will be presented and discussed. Recent results with the Smithwick procedure will be compared with those of the Peet operation.

Paper No. 17:

The Present Concept of Phlebothrombosis, Thrombophlebitis, and Embolism—Major LeRoy Kleinsasser, (MC), U.S.A., DeWitt General Hospital, Auburn.

The paper consists of a discussion of the technic and indications of sympathetic block, vein ligation, and aspiration of thrombus, phlebography, and a brief discussion of the relative rôle of anticoagulant therapy. The conditions specifically to be considered will be phlebothrombosis, thrombophlebitis, axillary thrombosis, migratory thrombophlebitis, suppurative thrombophlebitis, and chronic deep venous obstruction with lymphedema. The discussion will be accompanied by slides to illustrate cases and procedures. This will consist principally of the experience at the vascular center of the DeWitt General Hospital. (With slides.)

Paper No. 18:

Anticoagulants, Heparin and Dicumarol, Their Indications and Uses—Paul M. Aggeler, M.D., University of California Hospital, San Francisco.

In sufficient dosage the anticoagulant drugs, heparin and dicumarol will effectively prevent the formation of thrombi. They will not dissolve clots already formed, but will limit their further extension and will aid in the prevention of embolization from such thrombi. The danger of hemorrhagic complications limit the usefulness of these drugs.

Second Meeting
Monday Morning, May 7, 1945, at 10:00 a.m.
Meeting Room: Ball Room (Elks Temple)

SYMPOSIUM ON WARTIME MEDICINE

Paper No. 19:

Filariasis—Comdr. Richard B. Schutz, (MC), U.S.

N.R., Santa Margarita Ranch Hospital, Camp Pendleton, Oceanside.

Filariasis, little known in the United States, is a medico-military problem in global war. In the abscence of reinfection it is self-limited, is not expected to become a public health problem, but the characteristic recurrences of symptoms and findings make its differential diagnosis important for physicians caring for veterans.

Paper No. 20:

Aviation Medicine—Captain Louis E. Mueller, (MC), U.S.N., Senior Medical Officer, U. S. Naval Air Training Station, San Diego.

A brief history of the development of Aviation Medicine and the progress made in this field during the present war.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 21:

Cardiac Murmurs and Pain—Lt. Comdr. M. B. Filberbaum, (MC), U.S.N.R., U. S. Naval Hospital, Corona.

A discussion of the problem of cardiac murmurs and cardiac pain as related to the military personnel, its significance, differential diagnosis and disposition of the patient.

Paper No. 22:

War-Neuroses—Comdr. Walter Rapaport, (MC), U.S.N.R., U. S. Naval Hospital, Corona.

The problem of war neuroses presents no new questions. As it has been true for decades, the real challenge is to do something about a question which has been with us for many years. The symptoms and diagnoses present no great difficulties which would separate neuropsychiatric conditions found in war from those found in peace. The theories of treatment are many and varied and most have some commendable features. However, the exigencies of military service preclude handling and disposing of military cases in the same way as they can be handled and disposed of in civil life. The problem, therefore, becomes not what a war neuroses is, but what is to be done about it.

II

GENERAL SURGERY SECTION

Meeting Room: Lodge Room (Elks Temple)

H. Glenn Bell, M.D., *Chairman*
University of California Hospital, San Francisco

Leon Goldman, M.D., *Secretary*
University of California Hospital, San Francisco

Eugene J. Joergensen, M.D., *Assistant Secretary*
632 North Brand Boulevard, Glendale

Sunday, May 6, 2:00 p.m.

JOINT MEETING WITH SECTION ON GENERAL MEDICINE

Note.—Titles of Papers, with names of authors and abstracts are printed in the program of the Section on General Medicine, which precedes.

(a) *Panel Discussion of Diseases of the Liver.*
(b) *Panel Discussion of Vascular Diseases.*

Second Meeting

Monday Morning, May 7, 1945, at 10:00 a.m.

Meeting Room: Lodge Room (Elks Temple)

Paper No. 23:

Traumatic Perforation of the Colon Due to Nonpenetrating Abdominal Injury—Lt. Col. W. C. Sheehan, (MC), Chief of Surgical Department, Birmingham General Hospital, Van Nuys.

1. Presenting cases of intestinal perforation, accompanied by other severe injuries due to nonpenetrating abdominal trauma.

2. Cases, presenting unusual and vague symptoms.

3. Interesting problems of differential diagnosis as to systems involved.

4. Decision when to operate, supportive treatment, etc.

Paper No. 24:

The Crush Syndrome—Major Walter Birnbaum, (MC), Chief of Surgical Service, A.S.F. Regional Hospital, Camp Haan.

An old syndrome recently re-recognized during air raids on civilian population. Author's observation of the condition in London. Other instances of the same syndrome where the mechanism of injury was not characteristic; its relation to muscle ischemia and contractures, extra-renal azotemia and "shock"; the possibility of its being overlooked in cases of severe injury. (With slides.)

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 25:

Pulmonary Resections—John C. Jones, M.D., 1136 West Sixth Street, Los Angeles.

Indications and results from pulmonary resections in carcinoma of the lung, bronchiectasis, lung abscess and tuberculosis, including both lobectomy and pneumonectomy. (With slides.)

Paper No. 26:

Tuberculosis as a Surgical Disease—Lt. Comdr. J. E. Dailey, (MC), U.S.N.R., U. S. Naval Hospital, Corona.

A presentation and discussion of various surgical techniques utilized in the treatment of tuberculosis.

Paper No. 27:

The Treatment of Gunshot Wounds of the Face with Intra-oral Skin Grafts—Lt. Comdr. Michael Gurdin, MC-V(S), U.S.N.R., U. S. Naval Hospital, Oakland.

III
OBSTETRICS AND GYNECOLOGY SECTION

Meeting Room: Ball Room (Elks Temple)

ROY E. FALLAS, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

DANIEL G. MORTON, M.D., *Vice-Chairman*
University of California Hospital, San Francisco

PHILIP A. REYNOLDS, M.D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

Monday, May 7, 2:00 p.m.

Paper No. 28:

Chairman's Address—Roy E. Fallas, M.D., 1930 Wilshire Boulevard, Los Angeles.

SYMPOSIUM ON PSYCHOGENIC FACTORS IN OBSTETRICS AND GYNECOLOGY

Paper No. 29:

The Significance of Psychoanalysis for Gynecology—Ernst Simmel, M.D., 555 Wilcox Avenue, Los Angeles. (By Invitation.)

Psychoanalysis is a dynamic psychology. It studies the total personality and its somatic or mental functional disturbances as a result of the interrelationship between instinctual drives and reality factors, employing in particular its knowledge of the instinctual sources in the unconscious strata of the human mind. This paper deals with the specificity of the female personality, viewing disturbances in the functioning of the reproductive organ system as an expression of mental conflict.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 30:

Psychogenic Factors in Gynecology—George E. Judd, M.D., 1930 Wilshire Boulevard, Los Angeles.

This paper will consist of a discussion of gynecological symptoms that have psychogenic factors as a basis of their production.

Paper No. 31:

Psychogenic Factors in Obstetrics—Frances Holmes, M.D., 3780 Wilshire Boulevard, Los Angeles.

A discussion of emotional states accompanying child-bearing, their manifestations, and suggestions regarding management.

Paper No. 32:

The Emergency Maternity Pediatric Program (E.M.I.C.)—Some Observations Thereon—William Benbow Thompson, M.D., 1105 Equitable Building, Hollywood.

Report on procedures in the E.M.I.C. program of the Federal Children's Bureau of the U. S. Department of Labor. Some comment on war neuroses of wives of soldiers and sailors in military service.

IV
EYE, EAR, NOSE AND THROAT SECTION

Meeting Room: Lodge Room (Elks Temple)

WALTER R. CRANE, M.D., *Chairman*
1026 Roosevelt Building, Los Angeles

PIERRE VIOLE, M.D., *Vice-Chairman*
1930 Wilshire Boulevard, Los Angeles

LEWIS F. MORRISON, M.D., *Secretary*
490 Post Street, San Francisco

Monday, May 7, 2:00 p.m.

Paper No. 33:

Retinal Changes Associated with Diabetes (with slides)—Samuel Aiken, M.D., 384 Post Street, San Francisco.

A review of diabetic retinopathy with special reference to the newer concepts of the factors concerned with its development. The stages of the condition will be illustrated with fundus photographs. (With films.)

Discussion by Samuel Abraham, M.D., Los Angeles.

Paper No. 34:

Present Status of the Lempert Operation—Robert C. Martin, M.D., 384 Post Street, San Francisco.

The history and development of the Fenestration Operation. The types of cases which are suitable for operation. The average results obtained from properly trained, skilled operators and a discussion of factors as yet unknown including the arrest of the process on the operated ear and the duration of the results if the fenestrum remains open.

Discussion by Howard House, M.D., Los Angeles.

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Business Recess

Business Meeting and Election of Officers

Paper No. 35:

Corneal Transplantation—C. H. Albaugh, M.D., 727 West Seventh Street, Los Angeles.

Corneal transplantation should now be in the surgical armamentarium of every practicing ophthalmologist. Indications, contraindications, and the Castroviejo technique will be discussed. A moving picture in color will be used to demonstrate the technique used in a case of keratoconus. (With films.)

Discussion by Martin I. Green, M.D., San Francisco.

Paper No. 36:

Recent Advancements in the Treatment and Care of the Deafened: Report on the New California State Program for Conservation of Hearing—W. D. Currier, M.D., 65 N. Madison Avenue, Pasadena.

This paper will attempt to answer the age-old question, "What shall I do with the deafened patient?" The hard of hearing child will be especially discussed. A résumé will be made concerning modern concepts of treatment. A discussion will be given relative to the new California State program for conservation of hearing.

Discussion by Warren H. Gardner, Ph.D., State Department of Public Health.

Paper No. 37:

Amblyopia Ex Anopsia in the Armed Forces—Captain George E. Morgan (MC), U.S.A., A.A.F. Regional Hospital, March Field, Riverside.

A detailed analysis of eighty cases of Amblyopia Ex Anopsia found in the Armed Forces was reported. In a case history taken on each of these cases an attempt has been made to determine the type of treatment which a patient has received and the age at which it was initiated. Reference is made to a group of amblyopic cases treated in children and a correlation between these two groups to determine what percentage of improved visions could have been obtained under early and proper treatment. (With slides.)

Discussion by John Lordan, M.D., Los Angeles, and Loris L. Henry, M.D., Pasadena.

Paper No. 38:

The Use of Products of Fibrinogen and Thrombin in Otolaryngology—Captain Harry P. Schenck (MC), U.S.N.R., Santa Margarita Ranch Hospital, Oceanside.

Fibrinogen, used with a solution of thrombin, finds a wide range of usefulness in otolaryngologic surgery. These products of human plasma fractionation, wholly composed of proteins native to human blood plasma, provide an absorbable hemostatic agent which induces minimal tissue reaction. While in no way replacing the orthodox methods of providing hemostasis in arterial hemorrhage, they are an important supplemental hemostatic agent in mastoid and sinus surgery.

Discussion by Madeleine Fallon, M.D., Los Angeles.

V
ANESTHESIOLOGY SECTION

Meeting Room: Second Floor (County Society)

C. Eugene Schuetz, M.D., *Chairman*
6253 Hollywood Boulevard, Hollywood

Charles J. Betlach, M.D., *Secretary*
3023 Serena Road, Santa Barbara

Sunday, May 6, 2:00 p.m.

Paper No. 39:

Chairman's Address—Lumbosacral Subarachnoid Block—C. Eugene Schuetz, M.D., 6253 Hollywood Boulevard, Hollywood.

A brief history of its early use. Preparation of the patient, including medication and position. Technique in detail of the injection. Indications and contraindications. Other uses of this approach are given. Results of one hundred cases reported.

Paper No. 40:

Regional Anesthesia in Military Practice—Captain John F. Rhodes (MC), U.S.A., Letterman Hospital, San Francisco.

The application of regional anesthetic methods and agents to military personnel and under military conditions is covered. Emphasis is placed on the technique of brachial plexus block and regional blocks of the lower extremity.

Business Recess

Business Meeting and Election of Officers

Paper No. 41:

Cardiac Pathology as Related to Anesthesia—Major Gordon C. Langsdorf (MC), U.S.A., DeWitt General Hospital, Auburn.

A review of cardiac disease and complications as related to anesthesia for surgical operations with a brief outline of their management during the preoperative, operative, and postoperative periods.

Paper No. 42:

The General Visceral Afferent System and Its Relation to Anesthesia—Lieutenant V. H. Kuenkel (MC), U.S.A., Letterman Hospital, San Francisco.

This paper reviews the origin, development, and anatomical distribution of the fibers of the visceral afferent system, describing their relation to peripheral and autonomic nervous systems. Included is a description of the levels at which these fibers enter the central nervous system and the techniques used in temporarily interrupting them.

Paper No. 43:

Methedrine as a Vaso-Constrictor in Spinal Anesthesia—B. M. Anderson, M.D., Samuel Merritt Hospital, Oakland.

Three vaso-constrictors were used in a series of 450 consecutive unselected spinal anesthesias. Their effectiveness in controlling blood pressure is evaluated and the conclusion is drawn that methedrine has some superiority over the other two agents.

Paper No. 44:

High Segmental Spinal Anesthesia for Caesarean Section—S. W. Sensiba, M.D., 930 Fourteenth Street, Santa Monica.

In Caesarean sections it is desirable to deliver babies with unhampered respiration, and to protect the mother as much as possible against complications incident to pregnancy. Blocking a few segments, producing band anesthesia of the trunk, disturbs physiologic support so little that these objectives are more easily attained.

Discussion by John Hutton, M.D., Portland, Oregon.

VI
DERMATOLOGY AND SYPHILOLOGY SECTION

Meeting Room: Second Floor (County Society)

John L. Fanning, M.D., *Chairman*
1127 Eleventh Street, Sacramento

Clement E. Counter, M.D., *Vice-Chairman*
117 East Eighth Street, Long Beach

Otto P. Diederich, M.D., *Secretary*
1214 Mattei Building, Fresno

Monday, May 7, 9:00 a.m.

Paper No. 45:

Chairman's Address—Common Recalcitrant Dermatoses—John L. Fanning, M.D., 1127 Eleventh Street, Sacramento.

Paper No. 51:

The Corneal and Pharyngeal Reflex in Dermatological Diagnosis—William Mulvehill, M.D., 153 South Lasky Drive, Beverly Hills.

An investigation into the occurrence of a corneal and pharyngeal reflex in various groups of hospital and clinic patients as well as groups of physically and mentally normal university students. The subjects of this study are classed as to age and sex. Roughly, a pathological classification is made. Included also is a group of patients from the psychopathic wards. The purpose of this study is to determine what the incidence of corneal and pharyngeal reflex is in normal individuals and those suffering from various diseases and whether this sign can be an aid in the diagnosis of such conditions as factitial dermatitis or neurogenous excoriation.

VII

INDUSTRIAL MEDICINE AND SURGERY SECTION

Meeting Room: Rotunda Room (Elks Temple)

Floyd F. Thurber, M.D., *Chairman*
6065 Hollywood Boulevard, Los Angeles

John E. Kirkpatrick, M.D., *Vice-Chairman*
516 Sutter Street, San Francisco

Richard J. Flamson, M.D., *Secretary*
523 West Sixth Street, Los Angeles

Sunday, May 6, 2:00 p.m.

Paper No. 52:

An Evaluation of Methods of Treatment of Compound Fractures in the Shaft of the Femur—Lt. Col. Ralph Soto-Hall (MC), A.U.S., and Lt. Col. Thomas Horwitz (MC), A.U.S., Sixth Service Command, Chicago.

A study of end results of 163 fractures of the femur treated by various methods, including a large number of secondary closures. Conclusions as to the factors leading to successful delayed closure and to those methods of treatment which result in the best function. (With slides.)

Paper No. 53:

Surgery of Over 5,000 Fracture Cases Treated in the Richmond Shipyards—C. C. Cutting, M.D., Permanente Foundation Hospital, Oakland.

The fractures treated by the staff of the Permanente Foundation Hospital during two and one-half years are classified as to incident and site, with statements regarding the general trends of specific treatment and management.

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Business Recess

Business Meeting and Election of Officers

Paper No. 54:

Fractures of the Carpal Scaphoid—Major Robert E. Hastings (MC), A.U.S., Santa Ana Army Air Base, Santa Ana.

(No abstract submitted.)

Paper No. 55:

Simple Fractures of Both Bones of the Lower Leg—Samuel Matthews, M.D., 1913 Wilshire Boulevard, Los Angeles.

A discussion on recurrent dermatitis of fingers and hands, recurrent Acne Vulgaris, Lichen Planus, etc., with some clinical ideas on biologic and physical agents in treatment.

Paper No. 46:

The Diagnosis of Early Lepromatous and Neural Leprosy—Harry L. Arnold, Jr., M.D., The Clinic, Honolulu 53, Hawaii.

Lepromatous leprosy is characterized by granulomatous skin lesions, abundant bacilli, variable nerve lesions, and a progressive downhill course. Neural leprosy is characterized by hypopigmented and sarcoid-like skin lesions, scanty bacilli, variable nerve lesions, and a tendency to spontaneous arrest and healing. These forms are distinguished in practice by a search for bacilli and, if bacilli are abundant, biopsy.

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Business Recess

Business Meeting and Election of Officers

Paper No. 47:

Penicillin in the Treatment of Early Syphilis—Charles W. Barnett, M.D., Stanford University Hospital, San Francisco.

The results of the treatment of approximately 100 cases of primary and secondary syphilis are described, the longest post treatment period of observation being a year and a half. Various schemes of treatment are discussed and the limited literature is summarized.

Paper No. 48:

Delusions of Parasitosis (Acarophobia)—J. Walter Wilson, M.D., 2007 Wilshire Boulevard, Los Angeles; and Hiram E. Miller, M.D., 384 Post Street, San Francisco.

The paper sets forth reasons for the adoption of an improved name for this symptom complex, gives a résumé of the differential diagnosis of the psychiatric conditions in which it occurs and offers a guide to the dermatologist in treating such patients. The pertinent literature is reviewed and all of the recorded cases are tabulated, together with more detailed accounts of seven hitherto unpublished cases of the authors.

Paper No. 49:

Tyrothricin in Skin Infections—Harold E. Anderson, M.D., 117 East Eighth Street, Long Beach.

A review of some of the literature concerned with the bactericidal agent, tyrothricin, is presented. Clinical and bacteriological experiences are included.

Paper No. 50:

Seborrhea—Psoriasis and Related Diatheses—Hal E. Freeman, M.D., 117 East Eighth Street, Long Beach.

This paper will give the author's concept of various conditions called "seborrhea" and opinions regarding seborrhea-psoriasis on the coast. The discussion of diagnosis and treatment will be from the point of view of practicable office procedure. Adequate Kodachrome slides will be presented illustrating the conditions and their different diagnoses.

The purpose of this paper is to present a series of simple fractures involving both bones of the lower leg which have been treated by internal fixation or by conservative methods; analysis of their period of hospitalization; period of disability; and what per cent went on to nonunion.

Paper No. 56:

Bone Grafting in Compound Fractures with Nonunion —Lt. Col. Richard B. McGovney (MC), Chief Orthopedic Section, Birmingham General Hospital, Van Nuys.

This paper deals with the indications, technique, preoperative and postoperative conditions in thirty fractures of the extremities with nonunion treated by bone grafting. Preoperative treatment from time of injury to bone grafting is described. Points in surgical technique that are stressed are: adequate exposure, careful removal of fibrous and scar tissue and avascular bone, functional alignment, preparation of the graft bed, rigid fixation by metal plates and screws, generous use of cancellous bone in remaining defects, and bone end drilling. Illustrations are by lantern slides of pre- and post-operative conditions. (With films.)

Paper No. 57:

Low Back Pain: Neurological Considerations—George H. Patterson, M.D., 1052 West Sixth Street, Los Angeles.

Diagnosis, treatment, operative findings, advisability of accompanying fusion, end results.

Paper No. 58:

Treatment of Post Traumatic Quadriceps Contracture —Albert H. Rodi, M.D., 1136 West Sixth Street, Los Angeles.

(No abstract submitted.)

VIII
NEUROPSYCHIATRY SECTION

Meeting Room: Parlor A, 4th Floor (Elks Temple)

Clarence Wilmot Olsen, M.D., *Chairman*
1136 West Sixth Street, Los Angeles

Herbert E. Chamberlain, M.D., *Secretary*
P. O. Box 933, Sacramento

Monday, May 7, 10:00 a.m.

Paper No. 59:

Chairman's Address—The Effect of Cerebral Vascular Accidents on the State of Consciousness—Clarence W. Olsen, M.D., 1136 West Sixth Street, Los Angeles.

The following questions are considered: How do focal and widespread disturbances of cerebral circulation affect the state of consciousness? Of what localizing value is partial or complete loss of consciousness accompanying cerebral vascular accidents?

Paper No. 60:

A Critical Appraisal of the Mental Examination in State Hospitals—Joseph Perlson, M.D., Patton State Hospital, Patton.

The formal mental examinations in state hospitals are mainly historical and descriptive, and often present no understanding or knowledge about the patient. They are done at the convenience of the examiner and mostly for his gratification. Therefore, they could well be eliminated. The real issues are masked by emphasizing minutiae, and little therapeutic use is or can be made of them. It may hamper the study of psychogenesis. The keynote of psychotherapy should be socialization. Short, informal interviews in patient's hospital environment offers greatest possibilities. Success follows any well-administered method of psychological stimulation.

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Business Recess

Business Meeting and Election of Officers

Paper No. 61:

Introspection and the Orbital Cortex—J. M. Nielsen, M.D., 727 West Seventh Street, Los Angeles.

Physiologically speaking, man is above all animals by virtue of his capacity for self analysis. Anatomically, the one structure which is far more developed in man than even in the highest anthropoids is the orbital cortex. Experimentally, the work of Freeman and Watts and clinically the work of Kleist both corroborate this correlation. Obsession with self is lost when the orbital cortex is anatomically separated from its connections with the basal ganglia (With slides.)

Paper No. 62:

Subdural Hydroma: A Cause of Morbidity After Head Injury—William T. Grant, M.D., 1136 West Sixth Street, Los Angeles.

Collection of fluid between dura and arachnoid has been found to account for persisting, disabling symptoms after a head injury. Lumbar puncture or encephalography may yield suggestive or even confirmatory evidence of such a diagnosis. The severity of symptoms and the effectiveness of drainage by trephination seem to warrant presentation of collected cases. (With slides.)

Paper No. 63:

The Problem of Alcoholism—Paul Gliebe, M.D., University of California Hospital, San Francisco.

It is generally conceded that present methods for the treatment and rehabilitation of the alcoholic addict are unsatisfactory. The apparent success and growth of the Alcoholic Anonymous movement is discussed and an attempt is made to interpret the dynamic principles underlying their beliefs and teachings.

Paper No. 64:

Management of Ambulatory Psychiatric Patients at the Langley-Porter Clinic—Portia Bell Hume, M.D., Langley-Porter Clinic, The Medical Center, San Francisco.

The treatment of both psychotic and non-psychotic patients, including children and adults, on an outpatient basis, together with methods of investigation and followup of discharged in-patients.

Paper No. 65:

Psychosomatic Aspects of Headaches—Douglas Campbell, M.D., 2250 Pacific Avenue, San Francisco.

(No abstract submitted.)

IX

PATHOLOGY AND BACTERIOLOGY SECTION

Meeting Room: Parlor A, 4th Floor (Elks Temple)

James F. Rinehart, M.D., *Chairman*
University of California Hospital, San Francisco

James B. McNaught, M.D., *Vice-Chairman*
2398 Sacramento Street, San Francisco

R. H. Osborne, M.D., *Secretary*
312 North Boyle Avenue, Los Angeles

Alvin J. Cox, Jr., M.D., *Assistant Secretary*
2398 Sacramento Street, San Francisco

Monday May 7, 2:00 p.m.

Paper No. 66:

Chairman's Address—Studies in Thiamin Metabolism—James F. Rinehart, M.D., and L. D. Greenberg, M.D., University of California Hospital, San Francisco.

Sensitive methods for determination of the thiamin content of blood and tissues have been developed in our laboratory.

Controlled studies are reported on experiments with rats and monkeys which indicate that the concentration of thiamin in blood parallels that of tissues and reflects the intake. It is expected that estimation of blood thiamin in man will be a useful procedure in detection of thiamin deficiency. Observations on the myocardial lesion of thiamin deficiency in the rhesus monkey are reported.

Paper No. 67:

Lymphosarcoma. A Case Report—Howard A. Ball, M.D,. San Diego County Hospital, San Diego.

The patient was under observation almost continuously for a period of two and one-half years during which time numerous differential blood studies were made. The difficulties in diagnosis and the attempt to correlate the blood picture with the radiotherapy administered, together with post mortem observations, will constitute the report.

Discussion by Louisa E. Keasby, M.D., Los Angeles (by invitation).

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Business Recess

Business Meeting and Election of Officers

Paper No. 68:

Pathology in China—Charles L. Dale, M.D., 312 North Boyle Avenue, Los Angeles.

Observations on diseases occurring among Chinese refugees in the first years of the Sino-Japanese War. A comparison is made of certain degenerative diseases as seen in America, with the occurrence of the same lesions in the Chinese refugees.

Discussion by Hugh Edmondson, M.D., Los Angeles.

Paper No. 69:

Variations in Stomach Size—Alvin J. Cox, M.D., 2398 Sacramento Street, San Francisco.

A study of 100 stomachs shows marked variation in size and weight not explained by variations in body size. Some relationships to other conditions will be discussed.

Discussion by Ernest Hall, M.D., Los Angeles.

Paper No. 70:

Anatomical Demonstration of the Anovulatory Menstrual Cycle—Gert L. Laqueur, M.D., 2202 California Street, San Francisco.

A 12-year-old girl had menstruated regularly at normal intervals four times before sudden death from cerebral hemorrhage. The ovaries contained only one corpus luteum, although there were several atretic follicles and one thecal cyst.

Discussion by Angus Wright, M.D., Los Angeles.

Paper No. 71:

Clonorchiasis with a Case Report—James B. McNaught M.D., 2398 Sacramento Street, San Francisco.

A Chinese male, who had lived in the United States for 24 years, died two and a half months after a hemipelvectomy. A week prior to death, he became jaundiced. At autopsy, many hundreds of liver flukes (Clonorchis sinensis) were found in the bile ducts. These had undoubtedly been present for at least 24 years.

Discussion by Roy W. Hammack, M.D., Los Angeles.

Paper No. 72:

Morphological Effects of Abortifacient Pastes—A Clinical and Experimental Study—Reuben Straus, M.D., Cedars of Lebanon Hospital, Los Angeles.

At medical-legal autopsy histologic examination of the uterus of a woman aborted with an abortifacient paste, revealed an unusual lesion. The specificity of this lesion for the abortifacient paste was confirmed by an experimental study of its effects on uteri of pregnant rats and rabbits, together with in vitro tests.

Discussion by Edward M. Butt, M.D., Los Angeles.

Paper No. 73:

A Simplified Procedure for Erythrocyte Fragility—Reuben Straus, M.D., Cedars of Lebanon Hospital, Los Angeles.

The routine technique for erythrocyte fragility in standard textbooks of clinical pathology is relatively time-consuming. A simplified procedure is presented.

Paper No. 74:

The Histogenesis of Gitter Cells—William B. Dublin, M.D., 615 South Westlake Avenue, Los Angeles.

Gitter cells were previously thought to arise from the microglia. Recent work by Bagenstoss, Kernohan, and the writer has shown that most of them probably arise by proliferation of endothelium of small vessels and of adventitial cells. Experimental work on rabbit brain is here reported. Several illustrative lantern slides.

Discussion by C. B. Courville, M.D., and Clemson Marsh, M.D., Los Angeles.

Paper No. 75:

The Inverse Relation of Nuclear and Cytoplasmic Function—William B. Dublin, M.D., 615 South Westlake Avenue, Los Angeles.

Various authors have reported a daily rhythm of mitotic activity which varies in different animals. Blumenfeld showed that this rhythm is a function of individual organs. The writer is able to furnish a factual basis for the theory that nuclear and cytoplasmic functions lie in inverse proportion. Studies of endometrial glands are reported with illustrative lantern slides.

Paper No. 76:

The Kahn Verification Test—Rawson J. Pickard, M.D., 520 E Street, San Diego.

Mass blood testing has been the cause of many embarrassing false positive reactions. The verification test has in nearly all cases given a clear distinction between true syphilitic reactions and the general biologic reaction frequent after bacterial infections and in various conditions. False positives can be detected immediately by a simple test.

Paper No. 77:

Acute Epidemic Hepatitis: With Report of a Case of Spontaneous Rupture of the Spleen—Lt. Comdr. David A. Wood MC(S), U.S.N.R., U. S. Naval Hospital, Oakland.

Five cases of epidemic hepatitis from naval personnel in the San Francisco Bay area are presented. Four were acute and one subacute. The majority presented unique clinical manifestations—acute pachymeningitis hemorrhagica interna, hemorrhages in the mid brain with decerebrate rigidity, spontaneous rupture of the spleen and fatal hemoperitoneum. All the cases were endemic in their occurrence, although a fellow mate of the corpsman whose spleen spontaneously ruptured also developed a rapidly progressive, fatal jaundice.

Paper No. 78:

Unusual Cases of Leukemia—Captain Albert M. Snell MC(S), U.S.N.R.; Lt. Comdr. David A. Wood MC(S), U.S.N.R.; Lt. Comdr. Louis H. Dyke, Jr. MC(S), U.S.N.R.; and Bruce L. Canaga, Jr. (MC), U.S.N., U. S. Naval Hospital, Oakland.

Twelve cases of leukemia studied in the past year present a number of interesting and unusual features. Many of these cases were atypical and emphasize difficulties frequently encountered in establishing the diagnosis of leukemia especially when the peripheral blood shows a persistent "aleukemic" phase. One case persistently manifested typical finding of lymphocytic leukemia in the peripheral blood, yet at autopsy failed to show positive evidence of leukemia in the hematopoietic tissues. Two cases developed white blood counts as low as 350 which they maintained for as long as five days with eventual temporary remission. The rôle of penicillin in tiding such patients over the "critical" period is alluded to clinically. One case of lymphocytic leukemia simulated Hodgkin's Disease until rather late in its course when classical leukemic changes finally appeared in the peripheral blood. Lymphocytic leukemoid reaction and bizarre lymphocytic changes seen occasionally in patients under "sulfa" therapy is discussed. Fatal hemoperitoneum occurred in one case of myelogenous leukemia coincidental with peritoneoscopy examination. (With slides.)

X
PEDIATRIC SECTION

Meeting Room: Ball Room (Elks Temple)

Howard R. Cooder, M.D., *Chairman*
3875 Wilshire Boulevard, Los Angeles

Charles W. Leach, M.D., *Secretary*
2000 Van Ness Avenue, San Francisco

Chester I. Mead, M.D., *Assistant Secretary*
1930 Truxton Avenue, Bakersfield

Sunday, May 6, 2:00 p.m.

Paper No. 79:

Anoxia of the New-Borne—Frederick A. Fender, M.D., Stanford University Hospital, Clay and Webster Streets, San Francisco.

This paper has to do with anoxia with particular reference to predisposing causes during labor and also some notes regarding epilepsy as associated with it.

Paper No. 80:

Anomalies in Infants Following Rubella in Mother During Pregnancy—John J. Prendergast, M.D., 2001 Fourth Avenue, San Diego.

This paper deals with the subject of congenital cataracts in infants whose mothers have had German measles in pregnancy. There will also be a description of the type of cataracts observed. (With slides.)

Discussion by Carl Erickson, M.D., Pasadena, and Comdr. S. J. Winter, (MC), U.S.N.R., San Diego.

Business Recess

Business Meeting and Election of Officers

Paper No. 81:

Proctologic Problems of the Pediatrician—Edwin F. Patton, M.D., 267 South Beverly Dr., Beverly Hills.

An outline of rectal conditions frequently met in pediatric practice, not serious enough to require reference to a proctologist, with suggestions as to office management. (With slides.)

Paper No. 82:

Coronary Heart Disease: A Cause of Sudden Death in Children—David Davis, M.D., 9269 Brighton Way, Beverly Hills.

Two cases are presented illustrating Congenital Anomalies of the Coronary vessels resulting in sudden death. The literature is briefly reviewed and a classification of Coronary heart disease in children is offered.

It is suggested that Coronary heart disease be considered in all cases of Idiopathic Cardiac Hypertrophy in infants, and that the Coronary vessels be investigated in all cases of sudden death in childhood.

Paper No. 83:

Results of Bronchoscopy in Atelectasis of New-Borne Infants—Harold Owens, M.D., 1136 West Sixth Street, Los Angeles.

A brief summary of results will be given of cases of new-borne atelectasis treated by bronchoscopic aspiration and the indications for this procedure will be discussed.

XI
RADIOLOGY SECTION

Meeting Room: Rotunda Room (Elks Temple)

EARL R. MILLER, M.D., *Chairman*
University of California Hospital, San Francisco

JAMES B. IRWIN, M.D., *Secretary*
1831 Fourth Avenue, San Diego

Monday, May 7, 10:00 a.m.

Paper No. 84:

A Roentgen Study of Chronic Pulmonary Coccidioidomycosis with Special Reference to Persistent Primary Infections—Major Horace Jamison (MC), A.U.S., Santa Ana Army Air Base, Santa Ana.

The evolution of 96 coccidioidal pulmonary infections which persisted for months or years following the initial acute phase of the disease is discussed according to predominant roentgen manifestation: (1) Persistent pneumonitis. (2) Nodular parenchymal lesions. (3) Cyst-like cavities. (4) Mediastinal and hilar adenopathy. (5) Pleural effusion. Factors influencing dissemination are briefly discussed.

Paper No. 85:

War Chest Injuries—Lt. Comdr. Joseph P. O'Connor (MC), U.S.N.R., and Lieut. Henry L. Jaffe (MC), U.S.N.R., U. S. Naval Hospital, San Diego.

The radiographic and surgical considerations of a group of 165 chest casualties received from the Pacific Combat zone will be presented. Lantern slides of chest roentgenograms of these patients will be shown to illustrate the various types of war chest injuries and their complications.

The surgical management of hemothorax, empyema, fibrothorax and intra-thoracic foreign bodies will be discussed. (With slides.)

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Business Recess

Business Meeting and Election of Officers

Paper No. 86:

Photofluorography and Chest Diagnosis—David T. Proctor, M.D., 65 North Madison Avenue, Pasadena.

(No abstract submitted.)

Paper No. 87:

Aberrant Pancreas—Major Arthur J. Present (MC), A.U.S., Hoff General Hospital, Santa Barbara.

The finding of intramural or intraluminal defects in the antrum of the stomach due to this rather unusual condition in two cases with symptoms referable to the lesion makes their recognition important in the differential diagnosis of prepyloric lesions.

Paper No. 88:

Amebiasis: Its Roentgenologic Manifestations—Lt. Comdr. John D. Camp (MC), U.S.N.R., U. S. Naval Hospital, Oakland.

This discussion concerns the roentgenologic manifestations of amebiasis as observed in two large naval hospitals during the past three years. The fact that serious complications of this disease may masquerade without recognition of the underlying cause indicates the need for greater familiarity with its roentgenologic features. Roentgenologic changes observed in amebiasis involving the gastrointestinal tract, liver, and chest will be presented, together with pertinent clinical data.

XII
UROLOGY SECTION

Meeting Room: Second Floor (County Society)

PAUL A. FERRIER, M.D., *Chairman*
65 North Madison Avenue, Pasadena

DUDLEY P. FAGERSTROM, M.D., *Secretary*
710 Medico-Dental Building, San Jose

Section Aides:
PHILIP POTAMPA, M.D., Los Angeles
EARL NATION, MD., Pasadena

Monday, May 7, 2:00 p.m.

Paper No. 89:

Chairman's Address—Citizen Urologist—Paul A. Ferrier, M.D., 65 North Madison Avenue, Pasadena.

We have a heritage of freedom. What price medical regimentation? A consideration of the effect on quality of service and medical progress.

Paper No. 90:

Perinephritic Abscess Secondary to Renal Infection—Albert M. Meads, M.D., 251 Moss Avenue, Oakland.

The clinical symptoms arising from the acute and chronic forms of perinephric infections are contrasted. The latter type is usually secondary to renal infection, developing insidiously under cover of the original renal symptoms. Diagnosis is often thus delayed until extensive damage is done. Illustrative cases are presented. (With slides.)

Discussion by Adolph Kutzmann, M.D., Los Angeles.

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Business Recess

Business Meeting and Election of Officers

Paper No. 91:

Submucous Cystitis—Roger W. Barnes, M.D., 1216 Wilshire Boulevard, Los Angeles.

Submucous cystitis, or Hunner Ulcer, is a distressing disease to both the patient and the physician. The object of treatment is to increase the blood supply to the bladder mucosa and to increase the bladder capacity and prevent tonic contracture of the bladder. Therapy following these principles and which has been successful in relieving symptoms in 95 per cent of cases is given. A summary of 60 cases given this treatment is presented. (With slides.)

Discussion by Tracy Powell, M.D., Los Angeles.

Paper No. 92:

Enuresis in the Adult Male—Major Burton L. Stewart (MC), U.S.A., Pasadena Regional Hospital, 425 South Grand Avenue, Pasadena.

A consideration of this condition as encountered in a large military service, with a rationale as to etiology, pathology and a proper approach to cure.

Discussion by James L. Bray, M.D., Los Angeles.

Paper No. 93:

Transurethral Treatment of Bladder Tumors—Thomas L. Schulte, M.D., 909 Hyde Street, San Francisco.

The facility with which the cystoscopic treatment of bladder tumors can be employed, its low rate of morbidity and mortality, and its statistical end results are all factors which strongly endorse it as the preferred method of treatment. (With films.)

Discussion by Theodore Bergman, M.D., Los Angeles.

Paper No. 94:

Tumor and Cyst of the Urachus: Case Report—Robert J. Prentiss, M.D., 611 Medico-Dental Building, San Diego.

This patient presented the usual symptoms of hematuria. Cystoscopic findings were very suggestive. Biopsy revealed the tumor to be adenocarcinoma. The case is reviewed, with two others, and is recorded because of the rarity of the disease. (With slides.)

Discussion by A. J. Scholl, M.D., Los Angeles, and Lyle G. Craig, M.D., Pasadena.

Paper No. 95:

The Cherney Incision as Applied to the Surgery of the Bladder and Lower Ureter—Donald R. Smith, M.D., 384 Post Street, San Francisco.

This low transverse abdominal incision affords exceptional exposure for extensive surgery of the bladder and is peculiarly suited to ureterolithotomy for juxtavesical stone. (With slides.)

Discussion by Samuel K. Bacon, M.D., Hollywood.

XIII
PUBLIC HEALTH SECTION

Meeting Room: Retunda Room (Elks Temple)

J. C. Geiger, M.D., *Chairman*
101 Grove Street, San Francisco

George M. Uhl, M.D., *Vice-Chairman*
116 Temple Street, Los Angeles

Dwight M. Bissell, M.D., *Secretary*
City Hall, San Jose

Monday, May 7, 2:00 p.m.

Paper No. 96:

Chairman's Address—Public Health Bacteriology—J. C. Geiger, M.D., 101 Grove Street, San Francisco.

Bacteriology and its allies (Serology, Immunology, Mycology, Parasitology and Virology) cease to become separate entities and merge under the larger field—Medicine.

There are three general ways in which the relationship between physicians and public health laboratories of tomorrow will be strengthened:

First—From these laboratories will come information which will give us a stronger hold on our knowledge of the etiology of infections.

Second—We must not overlook the fact that technical improvements in the laboratories are likely to have an influence on medical practice and public health.

Third—A change in attitude. The increasing complexity of our existence is forcing specialization, whether or not we approve, and the burden of technical knowledge of the laboratory will be turned over to technicians and end the pretense of expert knowledge by physicians.

The relationship between the physician, the epidemiologist and the laboratory will improve with better coördination of effort.

It may be admitted that in our own brief lives we have become aware of the basic medical discoveries that have been made for increasing the life span and the happiness of mankind.

Paper No. 97:

Public Health and Preventive Aspects of Streptococcic Infections—Lowell A. Rantz, M.D., Stanford University School of Medicine, San Francisco.

The natural history of hemolytic streptococcal respiratory disease has been poorly understood. Recent investigation indicates that rheumatic fever is only part of a complex pathological process which is frequently initiated by infection by these organisms.

The control of rheumatic fever and the heart disease which frequently follows it, is intimately related to the elimination of infection by hemolytic streptococci. The rôle of the spread of disease by direct contact and by airborne bacteria must be considered.

Possible preventive measures include the reduction of exposure of susceptible individuals by isolation of infected persons and carriers, the elimination of the carrier state by chemotherapy, and the sterilization of the air by physical and chemical techniques. Another approach lies in the prevention of tissue invasion by streptococci by chemoprophylaxis and immunization. The potential value of each of these methods will be discussed critically.

✤

Business Recess
Business Meeting and Election of Officers

Paper No. 98:

Public Health Aspects of Rheumatic Fever in Naval Installations on the Pacific Coast—Comdr. R. F. Solley (MC), U.S.N.R., U. S. Naval Hospital, Corona.

(1) Epidemiology in relation to streptococcal respiratory tract infections; (2) Pathogenesis of Rheumatic Fever and its significance; (3) Importance of obscure, delayed or late manifestations of the disease; and (4) Group rehabilitation of Rheumatic Fever patients.

Paper No. 99:

Recent Observations on Virus Pneumonia—Monroe Eaton, M.D., 1392 University Avenue, Berkeley.

Several viruses may cause pneumonia in man, but

the most prevalent form of the disease called primary atypical pneumonia is probably of uniform etiology. A new virus transmissible to cotton rats, hamsters, and chick embryos has been isolated from both mild and severe cases and the majority of serums obtained from patients convalescing from the disease were shown to contain specific neutralizing antibodies for this virus. The use of the cold agglutination reaction and other serological tests as diagnostic aids will be discussed. Virus pneumonia caused by the psittacosis-ornithosis group is a relatively rare disease having clinical and epidemiological characteristics which differ from the more prevalent primary atypical pneumonia. The pathological findings in pneumonias caused by different viruses are not distinctive. (With slides.)

Paper No. 100:

Modernization of Quarantine Regulations for the Prevention of the Transmission of Tropical Diseases to the United States—Captain Thomas B. Magath MC(S), U.S.N.R., Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

A brief review will be presented of the background of quarantine procedures with special reference to those which relate to air traffic. The result of preventive medicine in military forces will be discussed and its effect on quarantine practices. Finally a code of regulations will be outlined designed to simplify the proceedings of entrance into a country through quarantine, taking advantage of newer knowledge of diseases and the methods of dissemination and prevention. (With slides.)

MILITARY FILMS

Lodge Room, Elks Temple, corner West Sixth Street and Park View

A series of military films, restricted, showing work of medical services in action have been secured through the courtesy of the military authorities.

These films will be shown on Sunday evening, May 6, in the Lodge Room of the Elks Temple. Films will be displayed between the hours of 8:00 and 10:00 p.m. C.M.A. members and their families are invited to view these films. No tickets of admission required.

Films listed for presentation include the following:

FB-147—"Medical Service in the Jungle" (20 min.).

FB-146—"Medical Service in the Invasion of Normandy" (22 min.).

TF 8-2090—"Ward Care of Psychotic Patients" (38 min.).

TF 8-1378—"Clinical Malaria" (25 min.).

COMMITTEE ON LOCAL ARRANGEMENTS

Executive Group

E. T. Remmen, Chairman

Louis G. Regan — George H. Kress, ex-officio

Ralph B. Eusden — S. K. Cochems

The Committee on Scientific Work arranged to use the facilities of the Elks Temple and the Los Angeles County Medical Association headquarters. Publicity concerning the programs was given in the *"Bulletin of the Los Angeles County Medical Association."*

Respectfully submitted,

E. T. Remmen, *Chairman.*

CHAPTER V

RE: COMPULSORY HEALTH INSURANCE BILLS PENDING IN 1945 CALIFORNIA LEGISLATURE (56TH SESSION)

California and Western Medicine for January, 1945, on pages 1-4 and 25-40 presented informative comments and items dealing with proposed Sickness Insurance laws for California.

In the issue of February, on pages 51-53 and 64-92 the items were continued as Chapter II of the series.

In the March number of California and Western Medicine the sequence appeared as Chapter III, pages 123-126.

Chapter IV had place in the April number, on pages 188-198.

In the present number of California and Western Medicine the sequence is given as Chapter V. (See pages 276-289.)

Indexes of Health Insurance Items

Indexes appear on the following pages:

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February (Chapter II)	64	I-LX
March (Chapter III)	123	I-XXX
April (Chapter IV)	188	I-XX

INDEXES: SICKNESS INSURANCE ITEMS

(The *index* of "Chapter I" of Sickness Insurance items, appeared in California and Western Medicine, for January, on page 40. The *index* of "Chapter II," appeared in the February issue, on page 64. "Chapter III" *index*, on page 123 of March issue; "Chapter IV" *index*, on page 188 of April issue. What follows, is the *index* for "Chapter V.")

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ITEM I

Governor Warren Fights His Party on Public Health Measure

Sacramento, April 4.—Governor Earl Warren clashed with Republican Assemblymen today on the issue of public health insurance, defying party leaders who warned that the Governor's whole legislative program would be wrecked unless he gave up his fight for his public health bill.

The Assembly public health committee voted last night to table the Governor's health bill and a rival C.I.O. measure.

"Not a Chance"

Sam L. Collins, Fullerton, Republican floor leader, asserted today:

"There isn't a chance in the world to pass this bill. If the Governor insists on attempting to bring this bill out of committee, it means a fight in the Republican ranks that will wreck his entire legislative program."

Almost immediately, Warren anounced that he would proceed with efforts to bring the bill to a vote, and also accused the committee of prejudice.

Criticizes Bill Foes

Commenting on the prospect of mustering the forty-one Assembly votes needed to bring the bill out of committee, Warren said at his news conference:

"If we get the votes, the bill will carry. If we don't it won't."

Angrily criticizing committee foes of his bill, the Governor said:

"It isn't very inspiring to see a legislative committee that is charged with such a responsibility announce, before it has finished its hearing, that it intends to chloroform all legislation on the subject."

Opposition Revealed

Warren was referring to disclosure yesterday, prior to hearings on the health bill, that a majority of committee members intended to vote to table the bill.

"I can hardly believe," Warren added, "that the Legislature is going to give a brush-off such as the Assembly committee gave to this tremendously important problem.

"It's very evident that, insofar as the committee was concerned, the matter was prejudged before the case was in."

Can't Trifle With It

Warren expressed confidence that the Legislature would give the subject "more serious consideration," and declared:

"It is so tremendously important to the public that people can't honorably trifle with it."

Warren said he never had tried to force passage of his bill or lobby for it, but merely had sought to make public his own views, and to answer questions of the public frankly.

Commentnig on Collins' statement, Warren said:

"Probably the wish is father to the thought."

Collins said he had been unable to see the Governor to confer with him regarding the measure although he had tried repeatedly to obtain an appointment.

Warren, at his news conference, commented:

"The door is open at all times to any legislator, and that means not any one of them, but all of them."

Hold Parley

Collins and Assemblyman C. Don Field (R.), Glendale, another opponent of the health bill, conferred with Assemblyman Albert C. Wollenberg (R.), San Francisco, who handled the bill for the Governor.

Collins and Field told Wollenberg that Republican sentiment was "overwhelmingly" against bringing the bill out of committee, and that he in all probability would be unable to get the votes to do it.

The committee voted, 7 to 3, against approving either the administration's Wollenberg bill or the rival C.I.O. Thomas measure.

Senator Byrl R. Salsman (R.), Palo Alto, said he would drop his companion measure to the Wollenberg bill in the Senate if the Assembly acted unfavorably.

To Give Notice

Both Assemblyman Albert C. Wollenberg (R.), San Francisco, and Vincent Thomas (D.), San Pedro, announced they would give the required two day notice of intention today to move for withdrawal of their bills from committee, which cannot be done before Friday at the earliest.

The committee's action late last night was not unexpected in view of the earlier report, but it came with surprising and dramatic suddenness during a final hearing on the compulsory health insurance legislation.

At the time, legislative auditor Rolland A. Vandegrift, a witness, was at a blackboard ready to jot down figures of estimated costs after clashing with Assemblyman Augustus F. Hawkins (D.), Los Angeles, who was interrogating him on the Thomas bill.

Caught Off Guard

Rising to interrupt, Collins moved to table the Thomas bill then and there. Hawkins, caught off guard, was stunned for a moment.

A colleague, Assemblyman Jack Massion (D.), Los Angeles, was on his feet, though, with a substitute motion to send the bill out with a favorable recommendation.

Assemblyman Fred H. Kraft (R.), San Diego, chairman, called the committee roll. The vote:

Aye—Hawkins, Massion and Edward M. Gaffney (D.), San Francisco.

No—Kraft, Collins, Fred Emlay (D.), Salinas; John W. Evans (D.), Los Angeles; C. Don Field (R.), Glendale; Richard H. McCollister (R.), Mill Valley and John F. Thompson (R), San Jose.

Assemblymen Ernest Debs, Ralph C. Dills and John Pelletier, all Los Angeles Democrats and committee members, were absent.

The vote was no sooner taken than Hawkins moved that the Wollenberg bill be recommended. This failed by the same vote.

Then Gaffney spoke up:

"I move we send out both bills without recommendation," he said.

"Oh, that's silly," remarked Field. "I move as a substitute to table—no, I move we adjourn."

"So ordered," declared Kraft—and it was all over.—San Francisco *Call-Bulletin*, April 4.

ITEM II

Battle Set to Force Vote on Health Plans

Supporters Will Attempt to Bring Bills to Floor of House

Sacramento, April 4.—Governor Earl Warren today voiced sharp criticism of the assembly public health committee for "chloroforming" compulsory health insurance legislation, as administration leaders mapped plans for carrying the fight to the floor of the lower house next week.

Assemblyman Fred Kraft, San Diego Republican and chairman of the committee, replied to Warren late today by declaring that the Governor's charges are not warranted by the facts and are a reflection "upon legisla-

tors who are doing an honest and thorough job on this subject."

7 Against

The cmomittee late last night refused "do pass" recommendations to the two major health insurance bills—A.B. 800, sponsored by the Governor, and A.B. 449, backed by the C.I.O. Seven of the thirteen committee members voted against sending the bills out—which means they are frozen in committee unless the assembly itself votes to take them out, which requires forty-one votes.

Assemblyman Albert C. Wollenberg, author of the administration bill, and Assemblyman Vincent Thomas, who introduced the C.I.O. measure, started proceedings to remove the bills from committee by giving formal notice of their intention. As at least two days must elapse between the notice and the actual attempt, Wollenberg and Thomas said no action would be taken until next week.

Warren Blunt

While Wollenberg and Thomas were giving their notices in the assembly, Governor Warren was lambasting the action of the public health committee in forthright language which made it plain that he was no little incensed.

"I can hardly believe," he said, "that the legislature is going to give a brush off, as the committee did, to this important problem. It was very evident, so far as the committee was concerned, the matter was prejudged before the case was in."

"Important"

"I sincerely hope and believe the legislature as a whole will accord the subject of health insurance more serious consideration than that. It is a matter so important to the public that they just can't honorably trifle with it."

He was asked about the committee's recommendation that in lieu of any action on health insurance at this legislative session, an assembly interim committee be appointed to make a two year investigation and report back in 1947.

"That's the chloroform," snapped Warren.

In Double Rôle

"In other words," Warren said grimly, "they wear one hat and decide to chloroform it, and wear another and decide to give it a fair hearing."

He made it clear that he has not tried to "lobby" the legislature on the bill, declared he regarded health insurance as "one of the most serious problems in the life of our State," and urged "full, fair, and not prejudiced consideration."

Told that Assemblyman Sam L. Collins of Fullerton, G.O.P. floor leader, had stated that if Warren forced the health insurance issue it would "wreck his entire legislative program," Warren commented: "Probably the wish is father to the thought."

Not Final

Wollenberg said today he did not regard the action of the Kraft committee as final, and that health insurance was far from being a "dead duck."

"Several opposition leaders have come to me today and urged me to drop the matter in view of the committee's stand," Wollenberg added. "They tried hard to convince me that we're through, but they were jittery. When they smile and aren't jittery, I'll believe it's a dead duck."

Await Caucus

Wollenberg and Thomas conferred with Assemblyman Alfred W. Robertson, chairman of the Democratic caucus, before giving their notices of motion to withdraw the bills from committee. They agreed not to press the motion until after the Democratic caucus, scheduled for Monday night. The Democrats are on record in support of health insurance.

The controversy over continued tax reduction is also expected to remain dormant until next week, as legislators on both sides of the issue sought today for ways to turn latest health insurance developments to their advantage.—San Francisco *Examiner*, April 5.

ITEM III

Health Bill Fight

Governor Warren Charges Assembly Group "Prejudged" Plan, Gave it "Brush-off"

Sacramento, April 4.—For the first time since he took office, Governor Warren today lashed out at a legislative committee. This was for giving what he described as the "brush-off" to his compulsory health insurance bill.

The Governor took the Assembly Public Health Committee to task for its action last night in precipitously blocking a vote by the Legislature on the compulsory health insurance issue. By a vote of 7 to 3, the committee refused to send either the Governor's bill or that of the C.I.O. to the Assembly floor for action there.

Assemblyman Albert C. Wollenberg, San Francisco, principal author of the Governor's bill, served notice on the Assembly today he would seek to bring the Warren Bill out of the Public Health Committee for a vote by the entire Assembly. It will require 41 votes to get the vote out of committee.

Warren characterized the proposal of the majority of the committeemen to delay action while a two-year study is being made by an Assembly committee as an intent "to chloroform all legislation" on the subject of compulsory health insurance. . . .—San Francisco *Chronicle*, April 5.

ITEM IV

Health Bill Treatment Irks Warren

Governor Charges Legislators Gave Measure "Brush Off"

Sacramento, April 4.—Governor Warren for the first time struck at a legislative committee when he charged today that the Assembly Public Health Committee had given his State health insurance bill "the brush off."

Warren made the charge at his morning press conference as a result of the committee action last night in voting down, 7 to 3, a motion to send out with a favorable recommendation both his bill and the one backed by the C.I.O.

Immediately thereafter handlers of the bills in the Assembly served notice that they will move to bring the bills out of committee by a vote of the Assembly. Assemblyman Alfred Wollenberg, handling A.B. 800 for the Governor, gave notice to the Assembly today.

Warren's Statement

"I can hardly believe that the Legislature is going to give a brush-off such as the Assembly Public Health Committe has given this important problem," said Warren. . . .

Serious Problem

"I have the greatest respect for the Legislature and its prerogatives and I wouldn't operate on any other basis regardless of how interested I might be in legislation. Acting that way, I believed that when I submitted one of the most serious problems in the life our State to the Legislature it should be entitled to a full and fair hearing and not be given prejudged consideration."

At this point he was told that Assemblyman Sam L. Collins of Orange, a member of the Public Health Committee who voted against the Governor's bill, had said that he thought the Governor ought to drop his compulsory health measure for "otherwise he will wreck his whole legislative program."

"All I have to say to that is that the wish is probably father to the thought," snapped the Governor.

The Governor was told that Collins has said he tried to see him several times without success. The Governor asked his secretary to check, and the report came back that some time ago Collins made an appointment with the Governor and it was kept.

Collins, who is Republican floor leader in the Assembly and is principal author of a voluntary health insurance measure sponsored by the California Medical Association, later said the Governor apparently was misinformed about his efforts to see him and he will now call on Warren and "talk things over with him."

"Brush-Off" Denied

Three of the seven committee members who voted against the Warren bill, asked if they had any comment on Warren's blast, denied there was a "brush-off." They are Collins, Fred Kraft of San Diego, chairman of the committee, and C. Don Field of Glendale, all Republicans.

Kraft pointed out the committe had held hearings over two months in San Diego, Los Angeles, Fresno, San Francisco and Sacramento, and two full hearings, afternoon and night, since the Legislature reconvened.

Sorry About Charges

"If that's giving a bill the 'brush-off' then we're guilty, I guess," said Field.

Kraft said he was "sorry" the Governor had made the charges, which Kraft called "a reflection upon legislators who are doing an honest and thorough job on this subject."

"The Governor's bill has been virtually rewritten three times and the C.I.O. bill twice, which is evidence that the proponents themselves are not sure of their ground and that more study is needed," Kraft said. . . . —Los Angeles *Times*, April 5.

ITEM V

Breach Widened for Warren Foes

Sacramento, April 5.—The first conference between Governor Earl Warren and Republican Assembly leaders on the Governor's compulsory health insurance program has widened the breach between Warren foes of the program, Republican Floor Leader Sam L. Collins said today.

Collins said he conferred last night with the Governor and Assemblyman Albert C. Wollenberg (R.), San Francisco, who is handling the Governor's bill.

The parley was the first between Warren and a spokesman for the bill's foes since the bitter clash yesterday between Warren and the Assembly Public Health Committee over the issue.

Stands Firm

Warren, according to Collins, refused to back down from his all-out support of his public health insurance bill and indicated he was ready for a wide-open fight on the Assembly floor.

Hold Trumps

With the Republicans widely split, the Democrats hold the trump cards, and both G.O.P. proponents and opponents of compulsory health insurance were wooing their votes.

The Governor's sharp rebuke to the Assembly Public Health Committee for refusing to recommend passage of his bill aroused much comment in both houses.

Collins and Assemblyman Fred H. Kraft, committee chairman, declared in so many words that the Governor didn't know what he was talking about. . . . —San Francisco *Call-Bulletin*, April 5.

ITEM VI

Warren Renews Health Fight

Governor Continues Hopeful for a Vote on Measures at Present Legislature

Sacramento, April 6.—Governor Warren today declared he did not "feel the cause of compulsory health is lost in this Legislature."

"I believe before the session is over the Legislature will recognize the tremendous importance and the serious problem involved in this issue and that it will do something about it," Warren told newsmen.

He made this statement after he was advised that Senator Byrl Salsman, handling his compulsory health bill in the Upper House, had indicated he would give up the fight if the Assembly does not grant Assemblyman Albert C. Wollenberg, leader of Warren's forces on the same issue, a vote on the bill.

On the subject of appointment of interim committees to study further the question already the subject of 30 years of legislative reports, Warren described that procedure as "just a polite way of entirely avoiding the issue and chloroforming the legistlation."

Assembly Vote Fight

Appointment of interim committees to study the controversial health problem further will be proposed in both Assembly and Senate next week. At the same time, the fight to get the health program before the Assembly will be started.

In the Senate, three members, Judah, Weybret and Breed, announced their intention of asking for the creation of a Joint Legislative Committee of six members with a $100,000 appropriation to conduct a study of health insurance during the coming two years.

Assemblyman Sam L. Collins, Chairman Fred Kraft of the Public Health Committee, Assemblymen Frank J. Waters, T. Fenton Knight and others signed a proposed resolution also creating a study committee but confining it to members of the lower house.

Collins, author of the California Medical Association's voluntary health insurance proposal, and Kraft were two of those who voted down compulsory health insurance bills in committee this week. They urged the study on the ground that "before intelligent action may be taken" on the issue, many matters must be inquired into in connection with the entire problem.

Eight Months Allowed

The size of the proposed Collins committee and the sum of money to be asked for its work will be determined later. The committee would report no later than eight months after the adjournment of the present session.

Unlike Senator Salsman, author of the Governor's bill in the upper house, Assemblyman Wollenberg, who has a companion measure in the Assembly, will not quit fighting this early in the session.

"I'm going right ahead and I haven't changed my mind one bit because of legislative developments in committee," said Wollenberg. "I still believe this session of the Legislature should act on health insurance."

Wollenberg will move about the middle of next week to get his bill out of the Public Health Committee so

that every member of the Assembly may vote on the compulsory health issue.

The proposed Senate interim committee would be empowered to obtain help from experts from the medical, insurance companies, farmers, hospital, industry and other fields of endeavor.

Senator Salsman said he believed "if there is not going to be any legislation then further study should be made, but it should be made by a joint legislative committee, instead of that of one house only." He believed the study should be turned over to experts in medical economics and persons with actuarial experience instead of over to representatives of the doctors, hospitals and industry.

Future of Salsman Bill

Salsman will not take up his bill in committee if Wollenberg is unsuccessful in getting the Assembly bill out of the Public Health Committee in the lower house.

Senator Judah said he thought a partial report at least should be ready for public perusal early in 1946 since the compulsory health issue appears certain to be on the ballot at the November general election.

The Democratic minority in the Assembly will caucus Monday night and discuss the compulsory health bill situation then. Democraitc county organizations, including the Los Angeles committee, have recently indorsed compulsory health insurance. Democratic State chairman William M. Malone has told his party members he would vote for compulsory health insurance, were he a legislator. County chairman Mike Fanning, likewise, is for it. Democratic leaders may be here next week to meet with the legislators.

Assemblyman Vincent Thomas, author of the C.I.O.'s bill, also will make a move to take his measure away from the Public Health Committee and bring it to the floor for a vote. . . . —San Francisco *Chronicle*, April 7.

ITEM VII

Warren Girds for Health Bill Fight

Sacramento, April 7.—Pressure groups for and against Governor Warren's compulsory health insurance program were busy today, while the Legislature was in recess for the week-end.

Although many observers believe that the legislation is already doomed, the Governor called upon Republican state and county leaders to use their influence in whipping recalcitrant G.O.P. assemblymen into line to support withdrawal of his bill from the Public Health Committee.

Concession of Defeat

A virtual concession of defeat on the part of the Governor's health insurance supporters was seen in a declaration by Senator Byrl Salsman, author of the Senate health bill, that "the best alternative" might be an interim legislative study.

The statement came after a trio of Republican senators disclosed they were preparing a resolution creating a joint legislative committee to supervise a complete interim health study.

At the same time the C.I.O. was endeavoring to rally labor and statewide Democratic groups to induce assemblymen to vote for putting their rival measure on the Assembly floor for consideration also.

In opposition, the California Medical Association and its allies, through home town doctors, dentists, druggists, nurses, hospital officials and others, bombarded legislators with telegrams urging them to keep all health service bills bottled up in committee.

Caucuses

Both Republican and Democratic lawmakers will hold separate caucuses Monday night to discuss strategy on health insurance, taxation and other issues. . . . —San Francisco *Call-Bulletin*, April 7.

ITEM VIII

Health and Taxes

Economy Bills, Health Insurance, County Subsidies Up for Vote Again

Sacramento, April 8.—Governor Warren's State tax cuts and his compulsory health insurance program will be before the Legislature again tomorrow as the Senate and Assembly begin the sixth week of deliberation since the constitutional recess. . . .

Health Insurance

Renewal of the fight over health insurance will be centered in the Assembly with the Senate also having a part in the controversy.

Governor Warren wants action at the present session on the health insurance issue.

In both the Assembly and Senate are moves to postpone any action now by creating interim study committees to make investigations and report on the health insurance problem.

While the argument goes on for the creation of interim committees, proponents of compulsory health insurance were organizing in an effort to bring out of the Assembly Public Health Committee both the Governor's bill and the C.I.O. sponsored Thomas measure on that subject. Both bills have been chloroformed in committee.

Chairman Fred Kraft of the committee contends his side will round up sufficient strength to prevent the bills from coming to the floor.

May Force Vote

Assemblyman Albert C. Wollenberg, San Francisco, who is handling the Warren bill in the Lower House, challenges this statement.

A coalition of supporters of the Governor's bills and those of the C.I.O. bill may result in forcing a vote on the issue.

Assembly Democrats are to caucus tonight and some of the party leaders are expected to recommend that the members follow the party platform and vote for compulsory health insurance.

Assemblyman Sam L. Collins, author of the California Medical Association's Voluntary Health Insurance Bill, is also the principal author of the Lower House resolution, setting up an interim committee to be named by Speaker Charles W. Lyon, also an opponent of compulsory health insurance.

Kraft wants the chairmanship of the committee. The gossip around the Capitol is that the C.M.A. group will ask that the San Diego druggist be named chairman if a committee is named. But others on the resolution have different ideas.

The Assembly interim committee, incidentally, is authorized to meet anywhere, even abroad if necessary, to study health insurance. On the Public Health Committee, whose majority smothered the two bills in committee the other night, are some of the "travelingest" members of the legislature. Just how many of them would be included on any special group for study purposes is conjectural.

The Republicans are also to caucus tomorrow night. But the compulsory health insurance issue has not been made a party matter by the G.O.P. Assemblymen. They will discuss taxes instead and try to agree on a campaign to approve the Governor's program on that subject.—San Francisco *Chronicle*, April 9.

ITEM IX

Assembly Due to Hold Showdown on Health Bills

Sacramento, April 9.—Paving the way for a long-awaited showdown on the controversial health insurance issue, the Assembly agreed today to vote tomorrow on motion to withdraw from committee both Governor Earl Warren's health bill and the rival C.I.O.-sponsored measure.

The parliamentary move—made over the protest of Republican and Democratic Assembly leaders alike—came as the Senate meantime prepared to vote this afternoon on the likewise controversial Hulse bill to earmark $100,000,000 of the State surplus for postwar subsidies to cities and counties.

Forty-one Votes Needed

Opponents of compulsory health insurance claimed neither the Warren nor the C.I.O. forces could muster the forty-one votes required to pull the two bills out of the public health committee.

Fred H. Kraft, San Diego assemblyman and chairman of the Assembly Public Health Committee—which last week recommended tabling of the health question pending an interim study—predicted the bills would remain in committee and die a natural death there.

Assembly Democrats still held the key to the entire health picture. Polls show that neither the Warren nor the C.I.O. bill could win without the support of a large percentage of the Democrats.

Further Probe

Assemblyman Sam L. Collins, Republican floor leader, introduced a resolution providing for further investigation of health insurance by an interim committee, to report to the Governor within eight months. Or at a special session if there should be one, prior to the next regular session.

An appropriation of $15,000 to finance the study was asked.

Assemblyman Vincent Thomas, San Pedro Democrat, author of the C.I.O. health bill, touched off the showdown move this morning when he moved to have his withdrawal motion considered as a special order of business at 10:30 a.m. tomorrow.

Several Coming

Democratic Floor Leader Alfred W. Robertson, Santa Barbara, suggested Thomas might let the action go over for two or three days, but the latter explained he had "several people coming up tomorrow morning and I don't want them to make an unnecessary trip."

Assemblyman Alfred C. Wollenberg, San Francisco, author of the Warren health measure in the lower house, immediately moved to have his bill considered tomorrow morning as well.

It was placed on the calendar for 10:35 a.m., immediately after the C.I.O. bill.

Both Republicans and Democrats will hold caucuses tonight to map further strategy.—San Francisco *Call-Bulletin*, April 9.

ITEM X

Health Bill Due for Vote in Assembly; Subsidy, Too

Sacramento, April 10.—The health insurance question was to come up for what may be its only Assembly vote today as the lower house received a Senate-approved bill to earmark 100 million dollars in State funds for local public works.

The Assembly vote was to be on whether the two health insurance bills held in the Public Health Committee would be withdrawn for consideration by the whole House. If the motions are defeated decisively, there probably will be no future action on the bills.

Assemblyman Wollenberg (R., S. F.), author of the health insurance bill favored by Governor Warren, claimed the 41 votes necessary to carry his withdrawal motion. Assemblyman Vincent Thomas (D., San Pedro), who introduced the C.I.O. bill, said he looked for a "close vote."

Results of caucuses by both Republican and Democratic assemblymen last night indicated the chief support for the motions would come from Democrats. A "very large majority" of the 29 assemblymen attending the Democratic caucus will support the motions, Assemblyman Alfred W. Robertson (D., Santa Barbara), minority leader, said.

Republicans failed to discuss health insurance at their caucus. However, Assemblyman C. Don Field (R., Glendale) expressed the flat personal opinion that the withdrawal motions would be defeated.

Before the Republicans held their caucus they dined at Capitol City Yacht Harbor Club as guests of Ben H. Read, lobbyist for the Public Health League, political wing of the California Medical Association, and Jay H. Kugler, legislative representative for the Dairy Institute of California.

Mr. Read insisted the dinner had no bearing on discussion of compulsory health insurance bills, which the medical association is opposing.

"Jay Kugler and I just decdied we'd pick up the check," said Mr. Read. "There's nothing to it—just an ordinary dinner. This seemed kind of a nice place for some drinks."

After paying the bill, the two lobbyists discreetly retired and left the assemblymen to caucus.

The Democrats, however, will pay for their own caucus dinners, said Assemblyman Robertson, waving a $400 check he received from the Jefferson Day Dinner Fund. He added the Democrats might accept a party from Mr. Read some time but explained he "didn't think" it would be a caucus dinner.

Resolutions to delay health insurance pending further studies were offered in both the Assembly and Senate.... —San Francisco *News*, April 10.

ITEM XI

Health Bill Killed

Assembly Votes to Shelve Issue in Committee

Sacramento, April 10.—Enactment of a compulsory health insurance bill at the current session was killed off today by the refusal of the Assembly to permit of a vote by its entire membership on that issue.

First test on the issue came when the Assembly refused 42 to 34 to withdraw from its Public Health Committee the C.I.O. sponsored Thomas bill.

Thirty-two Republicans, joined by ten Democrats, turned down Governor Warren's recommendation that the Legislature pass a prepaid medical care program based on compulsory health insurance now.

Only seven Republicans, Burns, Hollibaugh, Lyon, Maloney, Sheridan, Carey and Wollenberg voted with 27 Democrats in favor of Assemblyman Vincent Thomas' motion to bring his bill to the lower house for a vote. The Assembly committee chloroformed the compulsory health insurance bills last week.

The Absentees

Three Republicans and one Democrat were absent. Two of the Republicans were excused because of absence. One, Mrs. Kathryn Niehouse, only woman legislator, was excused because it was explained she was in San

Francisco on business although today was known to be the day of decision on the health insurance issue.

One Democrat, John B. Pelletier, Los Angeles, sat mute during the roll call and did not record his vote. Once during debate on the withdrawal motion, Speaker Lyon cautioned Pelletier about his language. The Los Angeles man had denied with a "damn liar" retort statements that the Health Committee of which he was a member, had not given a full hearing on the bills.

Assemblyman Thomas charged the Public Health Committee with "unfairness" in filing an adverse report to bills "before all the evidence had been presented," he said "we cannot allow this vital issue to be decided by a prejudiced committee." Thomas said labor, the Parent-Teacher Association, League of Women Voters and other organizations favored compulsory health insurance and that the members should not show political cowardice by refusing to get the bill on the floor where they could vote for or against it.

"Right of a Hearing"

Assemblyman A. F. Hawkins, Los Angeles, declared the question before the members was not that of compulsory health insurance but that the "issue is the right of a hearing" on the matter.

Assemblyman George D. Collins, Jr., San Francisco, also denied a full hearing had been granted on the issue, declaring "We are again asked to dodge the issue." He wanted the bill brought to the floor.

That chairman Fred Kraft had attempted to prevent questioning of witnesses by him at the San Diego and other hearings was charged by Assemblyman Jack Massion, Los Angeles. . . .

Assemblyman C. Don Field, Glendale, and Sam L. Collins, Fullerton, said a full hearing had been granted the proponents of both the C.I.O. and the Governor's bills. Collins said two months had been given over to the study. Pelletier had fixed the time at nine days and more than 50 hours, meaning the time the committee held hearings.

Dr. Sinai Attacked

One of the opponents, Chester Gannon, went completely afield from the issue at hand to attack Dr. Nathan Sinai, who testified as an economist in medical research, for the Warren bill. Sinai, now a doctor of public health and a University of Michigan professor, was attacked by Gannon as "a horse doctor." . . .—San Francisco *Chronicle*, April 11.

ITEM XII

Two Health Bills Killed by Assembly

C.I.O., Warren Bills Defeated

Sacramento, April 10.—The compulsory health program sponsored by Governor Earl Warren apparently was doomed to defeat today when the Assembly, by a vote of 38 to 39, refused to withdraw Assembly Bill 800 from the committee on public health. This means that the bill will remain buried in committee, leaving the Senate—openly unfriendly to the compulsory medical program—as the only remaining hope.

* * *

Sacramento, April 10.—The Assembly killed the compulsory health insurance bill sponsored by the C.I.O. today and late this afternoon was moving for a final showdown on the prepaid medical care measure supported by Governor Earl Warren as one of the major items on his 1945 legislative program.

The administration bill, introduced by Assemblyman Albert C. Wollenberg and others, apparently entered the fight in slightly better shape than the C.I.O. bill, sponsored by Assemblyman Vincent Thomas. Even Wollenberg, however, declined to predict victory in the impending parliamentary battle and the consensus was that he would fail.

End For Session

Defeat of the Wollenberg bill would dash any further hope of passage of compulsory health insurance legislation at this session. Senator Byrl Salsman, author of the companion administration bill in the upper house, already has indicated that he will not press his measure in the Senate if the Assembly bills fail.

Taken to Floor

In Los Angeles, meanwhile, supporters of compulsory health insurance were reported today to be preparing an initiative measure for submission in 1946. Petitions are now being drawn, it was reported here, under sponsorship of a group including the League of Women Voters, labor organizations and the Parent Teachers Association.

The test today was not on passage of the bills, but on motions to withdraw them from the assembly committee on public health, where a majority of seven members opposed to compulsory prepaid medical care had buried them.

Because of the committee's refusal to report out the bills, either with or without a recommendation, it was necessary to carry the fight to the floor of the Assembly on motions to withdraw from committee.

Two hours of debate preceded the vote on Thomas' motion to remove his bill from the unfriendly public health committee, which is headed by Assemblyman Fred Kraft, San Diego Republican.

The final roll call brought a vote of thirty-four "yes" and forty-two "no." Forty-two votes were required to pull it out of committee.

Those voting to bring the bill out of committee for debate on the floor included twenty-seven Democrats and seven Republicans; ten Democrats and thirty-two Republicans voted "no." Three members were absent and one declined to vote.

Lunch Hour Drive

The same procedure was followed in respect to the Wollenberg administration bill. After defeat of Thomas' motion, administration forces during the lunch hour conducted a whirlwind drive to pick up an additional seven votes, but with indications their best efforts would fall short. . . .—San Francesco *Examiner*, April 11.

ITEM XIII

Health Program

One Vote Stifles the Warren Bill; Fight to Go On

Sacramento, April 10.—Despite a serious rebuff by the Assembly, killing off a move to get a vote on compulsory health insurance by the entire membership of that body, Governor Warren tonight refused to concede final defeat of his program on that issue.

"It's a pretty hard blow to a great cause when the Assembly will not even let it be debated on the floor in the light of day," said Warren.

By a vote of 39 to 38, the Assembly defeated a motion by Assemblyman Albert C. Wollenberg, San Francisco, to bring Warren's bill out of the Public Health Committee for consideration by the Assembly.

"It is a rather sad commentary," said the Governor that the Compulsory Health Insurance bills, "cannot be brought out in the open and thoroughly debated on the floor of our legislative bodies but such is the power of the lobbies that have been against this legislation"

C.I.O. Bill Also Blocked

Before the Governor's bill was bottled up in the committee, the Assembly voted 42 to 34 against withdrawing from committee the Thomas C.I.O.-sponsored bill.

The Governor praised Wollenberg for "his spunk," saying, "I'll support him in any way." He said the fight in behalf of his bill was "against tremendous and powerful odds."

Wollenberg said he would not give up the fight to secure favorable consideration of his bill at this session.

Speaker Charles W. Lyon, one of those opposed to the legislation, said there was nothing to prevent Wollenberg from making another motion similar to that which proved unsuccessful today.

Asked how he felt about the Democratic support of his bill, the Governor replied: "I appreciate it."

Twenty-eight Democrats joined ten Republicans in the motion to withdraw the Governor's bill.

The G.O.P. Showing

Warren's only comment on the fact that only a few Republicans supported him was that he appreciated the help "of those who voted with us." The Republicans were Wollenberg, Burns, Carey, Fourt, Hollibaugh, Lyons, Maloney, Sheridan, Dickey and Waters. . . .

Democratic minority leader Alfred W. Robertson, who voted for the motions to bring the bills out of committee, said he felt the action today ended compulsory health insurance legislation for this session. . . .

Senator Byrl Salsman, Palo Alto, who has the Governor's bill in the Upper House, said he did not expect to make any further moves in view of the Assembly's action.

The final test today came on the Wollenberg motion to override the adverse action of the Public Health Committee.

Assemblyman Wollenberg presented arguments on why the measure should be voted on by the members. Assemblymen Gaffney, Doyle and others joined in the plea.

Only seven Republicans, Burns, Hollibaugh, Lyons, Maloney, Sheridan, Carey and Wollenberg voted with 27 Democrats in favor of Assemblyman Vincent Thomas' motion to bring his bill to the lower house for a vote. The Assembly committee chloroformed the compulsory health insurance bills last week.

The Absentees

Three Republicans and one Democrat were absent. Two of the Republicans were excused because of absence. One, Mrs. Kathryn Niehouse, only woman legislator, was excused because it was explained she was in San Francisco on business although today was known to be the day of decision on the health insurance issue.

One Democrat, John B. Pelletier, Los Angeles, sat mute during the roll call and did not record his vote. Once during debate on the withdrawal motion, Speaker Lyon cautioned Pelletier about his language. The Los Angeles man had denied with a "damn liar" retort statements that the Health Committee of which he was a member, had not given a full hearing on the bills. . . .—San Francisco *Chronicle*, April 11.

ITEM XIV

Legislators Clamp Lid on Health Bills

Move to Get Warren and C.I.O. Measures Into Open Balked

Sacramento, April 10.—The Assembly today apparently clamped the lid on compulsory health insurance legislation for this session when it voted to hold both Governor Warren's bill and the C.I.O.'s in committee.

On a motion to pull the C.I.O. bill out of committee the vote was 34 ayes to 42 noes. Later in the day a motion to move Warren's bill out lost by a vote of 38 to 39. It required 41 votes to take a bill out of committee.

Party Lines Crossed

Party lines were crossed in the voting, on the C.I.O. bill 27 Democrats and seven Republicans voted aye. Voting no were 32 Republicans and 10 Democrats. In the vote on the Warren bill 28 Democrats and 10 Rpeublicans voted aye and 29 Republicans and 10 Democrats voted no.

Last week the Public Health Committee voted seven to three against a motion to let the bills out of committee. Other bills on the subject are expected to remain in committee also.

Opinion of supporters of the C.I.O. bill generally is that the issue is dead for this session. In presenting the bill last January the C.I.O. said if it did not pass at this session the matter would be placed on the ballot. . . .—Los Angeles *Times*, April 11.

ITEM XV

Warren Charges Lobbies Beat Health Bills

Sacramento, April 11.—Compulsory health insurance bills were on the legislative scrapheap today as Governor Earl Warren blamed "tremendous and powerful influences" for blocking consideration by the entire Assembly.

He said he preferred not to name the lobbies opposing the measures. It was obvious he referred to the California Medical Association and its allies, including big business and farm groups, which led the attack.

While the Governor would not concede defeat most of his main supporters gave up the fight after the Assembly refused to withdraw his bill and a rival C.I.O. measure from its Public Health Committee to the floor for debate.

Friends said the greatest blow to Warren was the fact he was deserted by the majority of his own Republican party, and received the bulk of his backing from Democrats. Only ten Republicans voted for his bill, while twenty-nine were against it.

The Governor's keen disappointment was expressed at a news conference, where he assailed the Assembly action.

"This was a very severe blow," he said. "But I don't believe it's a lost cause just because we got knocked down.

"I am still hopeful the Legislature will do something about it before they adjourn.

"It's rather a sad commentary that the bills cannot be brought out into the open and thoroughly debated on the floor.

"But such is the power of the lobbies that have been against it." . . .—San Francisco *Call-Bulletin*, April 11.

ITEM XVI

Warren Hopes for 11th Hour Health Action

Charges Defeat So Far to Power of Medical Lobbyists

Sacramento, April 11.—Governor Warren today clung to hope for some kind of 11th hour favorable legislative action on his compulsory prepaid health insurance measure despite refusal of the Assembly to withdraw from committee for floor consideration either his bill or one backed by the California C.I.O. Council.

The Governor scheduled a meeting with Senator Byrl R. Salsman (R., Palo Alto), author of the Warren bill on the Senate side, to discuss possibilities of bringing the issue to vote in that House.

Governor Warren was lonely in his hope. Assemblyman Wollenberg (R., S. F.), who saw the Governor's proposal which he authored in the Assembly fall four votes short of victory in an intense session yesterday, was just about the only person among the 120 legislators who shared this hope. Senator Salsman was dubious but willing to try.

Assemblyman Vincent Thomas (D., San Pedro) author of the C.I.O. health insurance bill, said he had no plans for future action.

The Assembly first voted 42 to 34 against bringing the C.I.O. bill from the public health committee; then voted 39 to 38 against similarly withdrawing Governor Warren's bill. It required 41 votes to draw either to the floor.

The health committee voted 7 to 3 against recommending both bills after a majority of the members signed a report asking a two-year delay in insurance legislation while a new study is made.

"A pretty hard blow to a great cause" was how the unfavorable vote, which killed all possibility of future action in the Assembly, was characterized by Governor Warren at a press conference after the day-long Assembly contest. . . .

Lobbyists representing the doctors—principally Ben Read of the Public Health League of California; Dr. D. H. Murray, chairman of the California Medical Association legislative committee, and Attorney Howard Hassard—commented afterwards that they were by no means alone in the successful fight they had made against the bill.

They named as lobbies that had helped them kill the health insurance measures: the Chamber of Commerce, the insurance companies, agricultural and dairy interests, liquor interests, the merchants and manufacturers "and all representatives of business."

"The people don't want compulsory health insurance," they added.

"If you want to know who killed this bill," said Dr. Murray, "you should have been at the Los Angeles committee hearings and seen the business men come in to testify against it—all kinds of business men."

He pointed out that while the San Francisco delegation voted as a body in support of the health bills, "Los Angeles was split wide open, with pretty strong opposition from there." He cited the rural counties as another main source of opposition. Los Angeles business he credited with leadership in the fight.

The doctors' representatives said they expect the C.I.O. to prepare a measure for the ballot, seeking an initiative on health insurance, but as to their own plans for a counter measure on the same ballot, said simply, "It's one thought, but there is nothing definite planned."

Governor Warren, in discussing lobby influence on the measures, said he did not care to identify the groups which had been working against the bill. But he said it would be "interesting to see" what the Cailfornia Medical Association will do with their bill to promote voluntary health insurance. Author of this measure is Assemblyman Sam Collins (R., Fullerton).

How They Voted

Here is how the Assembly voted on the motion to withdraw Governor Warren's bill from committee:

FAVORING: Republicans — Burns, Carey, Dickey, Fourt, Hollibaugh, Lyons, Maloney, Sheridan, Waters, Wollenberg; Democrats—Anderson, Beal, Beck, Bennett, Berry, Brady, Brown, Burkhalter, Collins, Degs, Dekker, Dills, Doyle, Dunn, Emlay, Flecher, Gaffney, Haggerty, Hawkins, Kilpatrick, Lowery, Massion, McMillan, O'Day, Pelletier, Robertson, Rosenthal, Thomas.

OPPOSED: Republicans—Boyd, Burke, Butters, Call, Clarke, Sam L. Collins, Davis, Denny, Erwin, Field, Gannon, Geddes, Johnson, Knight, Kraft, Leonard, McCollister, Miller, Price, Sherwin, Stephenson, Stewart, Stream, Thompson, Thurman, Watson, Weber, Werdel, Charles W. Lyon; Democrats—Allen, Crichton, Crowley, Clayton Dills, Evans, Guthries, Heisinger, King, Middough, Sawallisch.

ABSENT — Republicans — Armstrong, Niehouse and Thorp.

Three Republican Assemblymen who voted for the Governor's bill—Dickey, Fourt and Waters — earlier voted against the C.I.O. measure. Assemblyman John Pelletier (D., L. A.), a member of the health committee, failed to vote on the C.I.O. measure but voted for Governor Warren's bill.

Got a Full Vote

Anyone watching yesterday's activities from the gallery might have chalked up this key event as a relatively passive, unexciting day. For each bill, after introductory discussion by authors, and questions from a scattering of assemblymen, a "call of the House" was put on, doors were locked, and absentees hunted up to get a full vote on the measures.

During this waiting period each time the authors "worked the floor," as the effort to win-over fence-sitters is called. Armed with a rollcall, or list of all assemblymen, they went from desk to desk to argue with those who might be won over. It was a small and unproductive list. Most men knew before they started the day's session, whether they would vote to bring the health measures out for Assembly consideration or leave them buried in committee. When the authors were satisfied they had done all the persuading possible, they asked the call of the House to be lifted, and the voted recorded.—San Francisco *News*, April 11.

ITEM XVII

Parley on Health Plan

Sacramento, April 13.—A new attempt to enact some kind of a compulsory health insurance bill, despite its apparent defeat in the Assembly this week, was planned today after a conference between Governor Warren, legislators and interested citizens.

Senators Byrl Salsman and John F. Shelley said it was decided to try to work out compromise amendments to the Governor's bill in the Assembly.—San Francisco *Call-Bulletin*, April 13.

ITEM XVIII

Health Bill to Be Revived

Plans to Merge Measures Made at Meeting With Governor Warren

Sacramento, April 13.—Supporters of compulsory health insurance today were preparing for an immediate Statewide drive to revive the issue in the legislature, where it was at least temporarily buried last week by refusal of the Assembly to vote the two principal bills out of the Public Health Committee.

At a meeting with Governor Earl Warren, who made enactment of a compulsory prepaid medical and hospital care bill one of the major items in his legislative program, it was decided to weld the administration and the C.I.O. bill into a single measure in an effort to unify support which hitherto has been divided. A concerted Statewide pressure drive is planned to win support for the measure.

Backers Meet

Participating in the meeting were representatives of the Parent Teachers Association, California League of Women Voters, State Federation of Labor, Congress of Industrial Organizations, Assemblyman Albert C. Wollenberg, San Francisco, chief author of the administra-

tion sponsored bill; Assemblyman Vincent Thomas, chief author of the C.I.O. bill, and Senator Byrl Salsman, who is handling the administration bill in the Senate. . . .— San Francisco *Examiner*, April 14.

ITEM XIX

State Health Insurance

There's Talk in Sacramento of Trying to Work Out Some Sort of a Compromise Bill

Sacramento, April 15.—Suggestions for a more modified form of compulsory health insurance than provided in pending bills were heard here today as the Legislature prepared to meet tomorrow.

Moves to revive the compulsory health insurance issue were started last week when representatives of the Parent-Teachers Associations, League of Women Voters, the A.F.L., C.I.O. and those legislators sponsoring strong compulsory health insurance measures met with Governor Warren.

Proponents Confer

In the next few days Assemblyman Albert C. Wollenberg of San Francisco, who is handling the Governor's bill in the lower house, will call a meeting of the bill's proponents to settle on a bill satisfactory to all.

Meantime, talk has started that it might be possible to secure support for some type of compulsory health insurance which would have a more modest beginning than contemplated in either Governor Warren's bill or the C.I.O. measure.

One of the big arguments used against compulsory health insurance has been that the contemplated 3 per cent payroll tax would not be sufficient to finance the program.

An argument is that health insurance costs may be uncertain and it would be better to start on a less complete program than outlined in bills chloroformed in the Assembly Public Health Committee.

Supporters of both bills contend the programs can be adequately financed through the 3 per cent payroll taxes and that the cost bugaboo is a smoke screen put up by those opposed to compulsory health insurance.

Coauthors of both bills believe they can sit down and iron out differences and bring forth a bill satisfactory to all backers.

But whether they would be able to round up sufficient new support to bring their bill to the Assembly floor is a moot point. A more modified proposal might bring extra legislative help.—San Francisco *Chronicle*, April 16.

ITEM XX

Legislature Bogged Down

Eighth Week Starts Tomorrow, and All Major Issues Are Still to Be Settled

Sacramento, April 21.—The Legislature begins the eighth week of the current half of the regular session Monday with none of the major issues settled.

Unless some agreement can be reached which will attract support to a compulsory health insurance act from some of those who joined to block a vote by the entire Assembly on pending insurance bills, that issue has little chance of resulting in other than a further study by one of those traveling interim committees. . . .

Governor Warren's proposed reorganization of the State Department of Industrial relations is due for another hearing before the Assembly Industrial Relations Committee. The committee failed to meet last week and its scheduled discussion of the Lyons bill was put over until Thursday night.—San Francisco *Chronicle*, April 22.

ITEM XXI

Compulsory Health Insurance Bill Will Be Revived

California State Chamber of Commerce
350 Bush Street, San Francisco 4, California
April 16, 1945

According to newspaper notices, a concerted drive is planned by the State Administration, the California Congress of Parents and Teachers, California League of Women Voters, California State Federation of Labor, and the C.I.O. in an effort to win support for compulsory health insurance legislation.

The California State Chamber of Commerce, Agriculture and Industry, is opposed to all compulsory health insurance bills introduced in this session of the Legislature and favors the appointment of a commission to study the problem fully and completely.

It is *imperative that you* let your Senator and Assemblyman know what your opinion is on this matter. *Write them today.*

(Signed) California State Chamber of Commerce.

ITEM XXII

Letter of Assemblyman Ralph C. Dills of Compton, Los Angeles County, to Members of His Democratic Assembly Committee Regarding His Vote on Compulsory Health Insurance

(copy)

Dear Mr. Committeeman:

You have asked why I voted in opposition to the two Compulsory Health Measures when they came up for vote before the Assembly last week.

First, let me assure you that I'm happy to make an explanation.

It shows a close relation between the legislator and the voters of our district and it indicates an alert interest in Sacramento affairs.

That being the case, it means we can discuss these vital matters openly and honestly.

At the outset, let me say I am not opposed to the theory of making medical facilities available to more and more people at the most reasonable rates possible. It is but a milestone in democratic advancement.

However, I am far from convinced that the *compulsory* plans offered the Assembly and defeated by the members are the *best* plans.

Parenthetically, let me say that the authors of the measures themselves were afflicted by this confusion because the bills were being amended with lengthy changes almost right up to the moment the matter came up for final discussion.

* * *

There has been a great deal of misunderstanding as to whether or not the bills had a proper hearing.

A recitation of the details should clear that point:

The measures were introduced in the January session of the Legislature at which time the Health Committee was authorized to hold hearings throughout the State on the merits and demerits of the proposals.

During the month of January lengthy hearings were held in San Diego, Los Angeles, Fresno and San Francisco.

When the Legislature re-convened in March further committee meetings were held in Sacramento. And, finally, the entire subject of Compulsory Health Insurance was discussed before ALL the members of the Assembly when we resolved ourselves into a Committee-of-the-Whole for a full day's discussion.

The committee, after listening to all this testimony, reported negatively on the measure.

The proponents, though in the minority, attempted to bring the bill from committee for further discussion.

Further discussion, to me seemed utterly superfluous at this time since we had ALL heard ALL the arguments.

As a result, I voted with the majority against both bills.

I am certain you and the other County Central Committee members will have a clearer understanding of the history of the legislation from my explanation of the thoroughness which surrounded the discussion and the final futility of the opponents' attempts at passage.

As for some of my reasons for voting against these particular measures:

Letters, postcards and wires sent me from the voters of our district indicated an almost ten-to-one OPPOSITION!

These communications pointed out that now was hardly the proper time to enforce ANYTHING of a compulsory nature; that more than 800,000 men and women in the Armed Forces were out of the State and were being given no voice in the proposed legislation.

The American Legion and the Veterans of Foreign Wars claimed that returning war veterans would need none of the services being proffered, yet they would have to pay a part of the costs.

Employees from all lines of endeavor wrote they could not afford an additional payroll deduction of one and one-half per cent from the gross amount of their salary checks.

Likewise, many small merchants besieged me to oppose the bills because, being called upon to match the deductions made from their employees, the additional levy was likely to bankrupt many of them.

We must bear in mind that both employer and employee were to be taxed one and one-half per cent of their salaries up to $4,000 per year.

In ordinary times we might say:

"Well, why worry about the small business man? He simply passes his costs on to the consumer."

Let me point out first that WE are the consumers and WE would, in the last analysis, be called upon to bear the entire costs.

OPA, for the time being, becomes a factor in any proposed compulsory taxation.

With ceilings on most products, the employer; the small merchant, the grocer, the butcher or the baker, would have difficulty in finding a way to pass this charge on to the consumers.

The result would be that he would have to operate under existing ceilings and would be unable to boost prices to take into consideration the increased costs of doing business.

In many instances this increase in his costs could conceivably be the difference between profit and loss; between a successful or a bankrupt neighborhood store.

I have never considered any legislation good which legislates *small business out of business!!*

There were other factors too:

What of the danger of setting up a monopoly for one branch of the healing arts? Chiropractors and others were not included in either of the acts.

What of the danger of creating another tremendous bureaucracy of incompetents with a consequent deterioration in the quality of services rendered?

What of the ultimate costs?

The testimony we heard on costs was of a most conflicting nature. The proponents argued that the three per cent; one and one-half from the employer, one and one-half per cent from the employee, would be sufficient to pay the costs.

The Legislative Auditor *hired by* the Legislature and responsible *only to* the members of the Legislature estimated that the costs might run to $100,000,000.00 more than the figure held to by the proponents.

Keep in mind the Legislative Auditor is responsible *only* to the members *of* the Legislature. He holds his position only so long as he honestly advises after careful, painstaking study and research into the State's finances.

Being a recognized expert in his field, I have learned to place considerable value upon his judgment.

I reasoned that I could not in good conscience vote for a measure which not only called for additional payroll deductions but might also mean an additional levy of $100,000,000 or more upon the taxpayers of the State.

* * *

Rounding up this report, let me say I would not be giving you the complete picture unless I touched upon the *political phases* of the matter as well as the financial dangers.

The health move, for the most part, was publicized as a great social reform attempt on the part of Republican Governor Warren. (The "Nonpartisan" days are *definitely* over and the sooner *all* Democrats realize it the better off the Party will be!)

What the average voter does not take into consideration is the fact that the Administration—the *Republican* Administration, would have been given what amounts to Hitleristic control of medicine in California. The Republican Governor, rest assured, looking to build the tottering fences in *his* Party, would appoint Republicans to run this giant new State service.

Warren would have had the power, in one of the acts, to set up the effective date of its inauguration.

Conceivably, he might use it as one of his main campaign arguments for re-election. And, with a lot of *new* bureaucrats, *newly* placed on the State's payroll, you can be assured he would be automatically handed a huge *new* group of campaign workers—workers anxious to bring about a Republican success and with it bring about permanency to their *new* political jobs.

* * *

In conclusion, let me again emphasize:

I am certainly *not* opposed to any workable measure which will bring better health at lower costs to "Mr. Average Citizen."

A *workable* plan, I feel certain, can and should be devised.

In my opinion, it need not be compulsory. It should give the person paying the bill the right to choose his own type of service and his own choice as to doctors.

The cost should be known—exactly!

I will work and assist in every possible way to bring about such legislation.

However, the legislation I voted *against* was not my idea of *good* legislation for the reasons I have set forth.

May I thank you again for your inquiry on this particular subject.

I hope it will be my pleasure to hear from you again on any other matters of interest to the fine people of our district.

Respectfully yours,
(Signed) Clayton A. Dills,
Assemblyman 67th District.

ITEM XXIII

Compulsory Sickness Insurance in Russia, Germany and Austria

The following letter has been received from a member of the San Francisco County Medical Society:

To the Editor.—Sir—Inasmuch as the question of compulsory health insurance is an extremely live issue,

it occurred to me that you might like to have some data which I have accumulated.

If I could furnish you with the slightest evidence that any one of the systems of compulsory health insurance in force in many European countries either raised the level of health of their people or acted as a means of preventing illness, I would urge you to vote in favor of Governor Warren's "California Prepaid Health Service Act" otherwise known as AB 800. This bill provides for compulsory health insurance for all people earning up to $4,000 per annum.

I would go even further. If it could be shown that any system of health insurance, either compulsory or voluntary, would reduce the number of "absent sick days" in industry or would lower the percentage of draft rejections due to physical and mental defects, I would be for Governor Warren's bill 100 per cent.

The fact is—there is no evidence to support the contention that health insurance does any of these things.

I have visited Soviet Russia on three different occasions and have lived a total of two and one-half years in Austria and Germany. I have never heard either the proponents or beneficiaries of health insurance in these countries make any such claims. Their principle argument in favor of health insurance in their own countries is that it better distributes the cost of illness. It is true that it was after the institution of new public health systems that there occurred a rise in health levels in these countries. It is also true that compulsory health insurance was incorporated into them too. But many other factors were also incorporated into these new systems—health education, better distribution of doctors and clinics, improved modern methods of medicine and public health. These were the factors which the advocates of Russia's and Vienna's systems depended upon to raise the health level. No one of these advocates, so far as I can learn, expected the factor of compulsory health insurance to raise the health level; instead, it was introduced for another purpose—for the purpose of distributing the cost of medical care.

Soviet Russia inherited some stupendous health problems from the old régimé. Her infant mortality rate was 35 per hundred in 1913—the highest of any civilized country in the world. This compared with Norway's 6.5 per cent in the same year. Her general death rate was 27.2 per thousand—for all of Russia—likewise the highest of any civilized country in the world. She had only 12,500 doctors or one to every 12,000 people. They were badly distributed so that there was only one doctor to every 20,000 peasants. Her population suffered enormously each year from widespread epidemics of typhus, smallpox, diphtheria, venereal disease and trachoma. Czarist Russia came first in the world for the number of blind persons because of trachoma. These were some of the dramatic highlights in the health and sanitary situation at the time when Soviet Russia instituted her system of compulsory health insurance.

It must be kept in mind, when considering this compulsory plan of Governor Warren's, that we have no such health problems to solve in California. We have the lowest infant and general mortality rate in history. We have no epidemics. We have a fine group of well trained physicians. We do have a medical cost distribution problem to solve. The California physicians have set up the California Physicians' Service for the purpose of solving this particular cost distribution problem. This plan is voluntary, nonprofit and nonpolitically controlled.

As I see it, the distribution of medical cost is the only problem which we can hope to solve by any system of health insurance. We already have a voluntary plan in operation. I say get behind this plan rather than set up a plan that may be fraught with many evils impossible to foresee and which is bound to be expensive.

Sincerely,

Ralph Reynolds, M.D.

ITEM XXIV

Report on Health Insurance Bills

In its report on the health insurance bills, the Assembly Committee on Public Health reaches sound conclusions in existing circumstances. Anyone who tried to appraise the various bills on this subject before the Legislature and to reconcile the conflicting assertions of their proponents and opponents would find it difficult to disagree with the committee's finding that not enough study has been given to the broad subject of health insurance.

While recommending that action on any prepaid plan be deferred, the committee report leaves open the question of assistance to voluntary prepaid medical care organizations to enable them to extend their coverage "to substantially all of our citizens."

It recommends an interim committee to make a thorough study of the subject and report at the earliest possible date.

If the Legislature can evolve some plan to further the voluntary movement it might prove constructive Every effort should be made to accomplish the desired objectives on a voluntary basis before resort to compulsory methods. In this connection it is noteworthy that in Winnebago County, Illinois, under a voluntary medical care plan combined with a Blue Cross hospitalization plan, larger benefits are offered than those proposed in the compulsory bills before the Legislature and with premiums averaging much less than a 3 per cent pay roll tax.

With respect to the proposals to finance the compulsory plans by added pay roll taxation, it might be pertinent to consider the tax target that is being made out of pay rolls for existing and proposed social benefits which threaten to increase to 20 or 25 per cent the tax deductions from pay checks.

Even with provision that a compulsory health insurance pay roll tax measure would not be placed in effect during the war, the uncertainties surrounding the coming reconversion period in California do not make this a good time to launch such an experiment. Such a measure with its far-reaching social and economic implications should be subjected to thorough study before the Legislature attempts to pass on it.

Meantime the medical profession has an opportunity to exert more leadership and progressiveness than has marked it in the past in helping to solve this complex problem. Particularly in the field of health education, the doctors can and should exert a greater community influence in formulating community health programs designed to instruct people how to preserve health and to acquaint them with facilities available to them in case of illness. Progressive communities already have such programs functioning in conjunction with progressive employers.—Los Angeles *Times*, April 5.

ITEM XXV

Should We Have Government Health Insurance?

As debated before the American Economic Foundation by

Hon. Andrew J. Biemiller

Congressman, Fifth District, Wisconsin, Member Committee on Naval Affairs

and

Louis Hopewell Bauer, M.D.

Member, Bureau of Health Education, American Medical Association

* * *

Congressman Biemiller opens: Today the nation has accepted the general principle of social security. We have recognized most people cannot provide, through personal savings, for long periods without income because of unemployment or old age.

Social security, based on the insurance principle of spreading risk, helps people keep going in time of catastrophe. If the social security principle is sound for unemployment and old age, it is doubly sound in time of sickness. For then the person must provide not only for regular living expenses, but medical costs.

If the head of a family faces a severe illness with doctor and hospital bills, his savings and credit are soon exhausted, his family reduced from self-respecting independence to dependent poverty. This is harmful to the family and community.

Our next step must be to extend social security legislation to include sickness benefits—cash compensation for unemployment due to illness—and medical benefits. While the medical profession makes breath-taking daily advances in science, that science is not available to all because they cannot pay for what they need. The appalling physical condition of our young men, revealed by the very high rate of draft rejections, indicates this.

A health insurance scheme providing medical benefits would bring doctor and patient together by removing the money barrier. Such a plan can and must insure the patient's free choice of doctor, protect the relationship between patient and doctor and in no respect jeopardize the magnificent progress of medical science.

* * *

Dr. Bauer challenges: Congressman Biemiller argues for better distribution of medical care, not for government health insurance. The draft statistics are not appalling when analyzed. Of approximately 4,000,000 rejections, 800,000 were for illiteracy.

Nearly as many were for neuropsychiatric defects which would not have been prevented by more medical care. Some eyesight and structural defects might have been prevented by health education, not by medical care. Not over 400,000 could be rehabilitated and many of these refused.

All government systems make some restriction on choice of physician. All interfere in the doctor-patient relationship by interposing a third party. All jeopardize progress by regimentation and encouragement of poor work.

* * *

Congressman Biemiller replies: Choice of physician can be secured under a health insurance system if the medical profession coöperates. It cannot if many physicians refuse to come in. In any case, choice of physician is less important than access to physician when needed; many people do not have that today.

The doctor-patient relationship is more effectively sabotaged today by financial worry on both sides than it would be by a government guarantee of payment. Such standardization as would tend to raise levels is desirable; degree and kinds of standardization should, of course, be decided by a board of doctors under health insurance.

* * *

Dr. Bauer opens: Diagnosis and catastrophic illness make medical care expensive. This problem can be met by providing voluntary prepayment hospital and medical care insurance. Voluntary insurance provides cash for those with moderate incomes—medical service for those with low incomes.

The indigent class may be cared for by having the government purchase voluntary insurance. Then, the patient may choose his physician and the physician is responsible to him—not a bureaucrat. Preventive medicine may be obtained by adequate health services and laboratories provided by the local community or if the local community cannot afford it, by state or federal subsidies.

Government health insurance gives quantity, not quality in medical care. It is inordinately expensive, financed by a payroll tax. It has nowhere given as satisfactory a health record as the American system based on free enterprise. Preventable diseases increase. Malingering is encouraged. Working days lost increase instead of decrease.

A third party—the government—is interposed between doctor and patient—the doctor is responsible to that third party. Often, the patient may not choose his physician. Even where free choice is provided, it is limited because the better doctors refuse to take part.

Poor medical care is engendered; mass medicine results; diagnostic procedures are not encourgaed; the government interferes with prescribing, dictates the number of visits a doctor may make; the number of patients he may have. The doctor is no longer a family counselor. A tremendous bureaucracy develops with accompanying red tape and inefficiency.

* * *

Congressman Biemiller challenges: Experience showed voluntary plans failed to meet economic needs in providing for old age and unemployment and federal action was necessary. Federal health insurance is essential for exactly the same reasons.

Health insurance plans were introduced in Europe half a century ago to meet a desperate need. Since then they have been continually bettered. European doctors never asked for the abolition of plans. They suggested improvements. We can learn much from their experience and suggestions.

When American doctors approach the problem in the same spirit and devote the energy now spent fighting health insurance, we shall have the finest possible medical care for all our people.

* * *

Dr. Bauer replies: Voluntary health plans are rapidly growing. There is no evidence that, given time, they will not meet the need.

Government health insurance plans were introduced originally by Bismarck for a purely political purpose and not to meet a desperate need. Conditions have grown from bad to worse. The best plans in Europe are voluntary.

American doctors are planning widespread hospital and diagnostic facilities, and the insurance plans already mentioned. They will never submit to the regimentation of a government bureaucracy with its resulting poor grade of medical care.

Our present system should be improved by sound evolutionary methods and not discarded for an unsatisfactory revolutionary scheme.—Sacramento *Union*, April 8.

ITEM XXVI
Trends in Labor Movement

Washington.—Without prejudice and just for the fun of it, there are here set down a number of recently observable trends in what is known as "the labor movement," so that he who reads may also run his finger down the list and make his own conclusions on where this labor movement might be headed:

Union membership is now close to 14,000,000, or

roughly one out of every four persons in the labor force, one out of 300 industrial or nonfarm workers.

There are five principal groups within the movement, A. F. of L., C.I.O., Railway Brotherhoods,, John L. Lewis' United Mine Workers, and the Independents. Though these groups get together in various combinations for specific purposes, general unification of the labor movement in a common front seems to be making no progress whatever. A postwar economic setback might provide impetus for bringing them closer. In the meantime, lack of organic unity provides comfort and strength for other elements of the population which may have cause to fear the growing power of organized labor.

The need for a Department of Labor to serve as labor's spokesman in the halls of government has ceased to exist. Organized labor itself is interested and active in every phase of government activity. The labor lobbies are as powerful as any pressure groups ever established in Washington by industrial groups.

Both A. F. of L. and C.I.O., and the Railway Brotherhoods to a lesser degree, have completed legislative programs. U.M.W. goes after the things that affect the coal industry, but the other three have interests as broad as the national economy, covering education, taxes, racial discrimination, appropriations.

Practically no proposal comes up in Congress, practically no order is issued by an executive agency without drawing some comment of endorsement or disapproval from A. F. of L. President Bill Green or C.I.O. President Phil Murray.

Union officials sit on many war agency advisory groups. Union representatives sit on the National War Labor Board, passing judgment on its own controversies, though not always winning majority decisions to labor's liking.

The federal government has become so thoroughly saturated with the organized labor point of view that anti-labor forces have in many instances turned to the state legislatures to enact curbs on labor activities. In turn, the labor organizations are showing a greater interest in State and local government.

Activities of the C.I.O. Political Action Committee are well-known to everyone who showed any interest at all in the last national elections. While openly opposed by leaders of the other big labor groups, the P.A.C. program was unquestionably followed by many rank and file members of those other groups.

Many labor policy decisions on both international and national affairs are made by labor leaders and executive committees before reference to union membership. This had led to charges of dictatorship of the rank and file by its hierarchy. If such dictatorship exists, it can be viewed as a healthy thing in attempts to enforce such decisions as the "no-strike pledge." It can be viewed with alarm if it suppresses the freedom of thought or action of the rank and file.

Among the debatable major objectives of the labor movement these trends are worth watching:

Postwar full employment and increased social security. More and better public housing. Broader public health measures, including health insurance, hospitalization and even socialized medicine. Royalties on production to provide worker benefits.

Increased minimum wage and guaranteed annual wage. More maintenance of membership and closed shop agreements. Elimination of geographic wage differencials, leading to more national bargaining on an industry basis. Organization of foremen and supervisors. More labor-management coöperation in war production, perhaps leading to greater labor participation in management.

Add it all up and what have you?—Peter Edson, NEA Staff Correspondent, in Merced *Sun-Star*, March 29.

ITEM XXVII

Senator Fletcher Seeks State Vote on Health Bills

Fletcher Urges Referendum; Warren Backs Own Plan

Sacramento, April 19.—The legislative controversy over compulsory health insurance moved back into the spotlight today with four developments topped off by Senator Ed Fletcher's announcement he will seek to have the issue decided by California voters at the next general election.

Declaring there "is now very little possibliity of compulsory health insurance legislation being passed this session," the San Diego Senator said he will press for passage of a constitutional amendment declaring it to be the State policy to create a "prepaid health service system," and "directing and authorizing" the legislature to enact the necessary legislation.

"I feel it is presumptuous for us to try to pass compulsory health insurance legislation when over half of our physicians, so vitally interested in the matter, are now serving their country outside the State," Fletcher said.

"In addition, approximately a million of our citizens are absent while serving in the armed forces. They have, and should have a right to a voice in this matter."

While Fletcher was making this announcement, Governor Warren disclosed the administration has not abandoned its campaign for health insurance, despite a succession of legislative reverses. A conference with legislative leaders and representatives of various organizations supporting the program, Warren said, resulted in the "conclusion that the effort to solve the problem should not be abandoned for this session."

To Seek Means

Conferees, he said, will "try to find ways and means to put through something to accomplish the desired purpose."

A meetnig of the Senate social welfare committee meantime brought another development which may have a bearing on the health insurance picture. Senator John F. Shelley of San Francisco announced he may move either next Wednesday, or a week later, to bring his "disability insurance" bill to the Senate floor for consideration. No effort has been made thus far to move the measure from committee, presumably because of uncertainty over outcome of the health—insurance fight.

The sick benefit plan, in operation in Rhode Island, would set aside all employee unemployment insurance contributions in a "disability insurance fund." Benefits would be paid from this fund to persons otherwise covered by jobless insurance, but ineligible for this insurance because of illness or other injury.

Although its sponsors have given no indication whether they intend to seek action, an additional possibility lies in a Senate concurrent resolution calling for a joint committee on health insurance to obtain all the facts on the issue and report to the next regular session of the legislature. The committee would be composed of three members of the Senate and three Assemblymen, who would receive a $100,000 appropriation for expenses of the inquiry.—San Francisco *Examiner*, April 20.

* * *

(COPY)

SENATE CONSTITUTIONAL AMENDMENT No. 15

Introduced by Senator Fletcher

March 28, 1945

Referred to Committee on Public Health and Safety

Senate Constitutional Amendment No. 15—A resolution to propose to the people of the State of California

an amendment to the Constitution of the State by adding Section 27 to Article XX thereof, relating to a Prepaid Health Service System for the people.

WHEREAS, The policy for creating and providing for a Prepaid Health Service System for the people of the State, upon a compulsory basis, has not since 1918 (when a similar policy was submitted and rejected) been presented to the people for their consideration and adoption or rejection, and it is highly desirable that their mandate and instructions be sought and obtained before the Legislature assumes the prerogative of embarking the State upon such an important undertaking; now, therefore, be it

Resolved by the Senate, the Assembly concurring, That the Legislature of the State of California at its Fifty-sixth Regular Session commencing on the eighth day of January 1945, two-thirds of the members elected to each of the two houses of the Legislature voting therefor, hereby proposes that the Constitution of the State be amended by adding Section 27 to Article XX thereof, to read:

Sec. 27. It is the policy of the State that a Prepaid Health Service System for the people be created and maintained. The Legislature is authorized and directed to provide therefor by law in any manner not expressly prohibited by the provisions of this Constitution.

ITEM XXVIII

Health Insurance

Editor—In the Safety Valve, April 23, is a letter from Emma Jane Hicks of Berkeley, pointing out that the United States is one of few countries having no government supported health insurance, and expressing the hope that the State of California may lead the way in establishing such a project "if only its legislators will realize what it will mean to the people."

Fortunately, there are in our community many doctors who have lived and worked in countries having state-dominated health insurance programs. It is to be hoped that our legislators will avail themselves of the opportunity to secure from these men definite and specific factual information regarding the steady deterioration of medical care secured by the people under these programs. If our legislators do indeed realize what it will mean to the people, they will take good care to see that no such blight comes upon us.

HOBART ROGERS, Oakland.

—Letter taken from "Safety Valve" column of San Francisco *Chronicle*, April 27.

ITEM XXIX

Joint Health Bill Due Soon

Sacramento, April 26.—The next move in Governor Warren's recommendation for State tax cuts is up to the Senate. . . .

According to Assemblyman Vincent Thomas, San Pedro, a joint compulsory health insurance bill probably will be presented soon. It would embody features taken from both Governor Warren's bill and that of the C.I.O. which Thomas authored.

The original bills were chloroformed by the Assembly Public Health Committee some time ago and an effort to bring them to the floor for a vote of the entire membership of the lower house failed.

The new bill probably will bear the name of Assemblyman Albert C. Wollenberg, San Francisco, Thomas and others. . . .—San Francisco *Chronicle*, April 27.

ITEM XXX

Assembly to Get New Health Insurance Bill Next Week

Sacramento, April 26.—A new compulsory health insurance bill, embracing major features of the separate plans proposed by Governor Earl Warren and the C.I.O., and including chiropractors for the first time, probably will be introduced in the assembly next week, it was learned today.

William T. Sweigert, Warren's executive secretary; Paul Pinsky, C.I.O. legislative representative, and others were reported putting finishing touches on the draft.

The original bills embodying the separate health insurance plans have been pigeon-holed by the lower house Public Health Committee and the Assembly has refused to withdraw them for debate on the floor.

With the administration, C.I.O., A.F.L., P.T.A., and other groups joining hands in favor of one piece of legislation, proponents of compulsory insurance anticipate that while the Public Health Committee probably will pigeon-hole the new measure also, they will have more of a chance to pull the bill out of committee through vote of the Assembly.—San Francisco *Examiner*, April 27.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

On G.I. Bill of Rights—In Relation to Postwar Medical Courses for Military Colleagues

Letter from National Committee on Postwar Medical Service to Governor Earl Warren of California:

(COPY)

COMMITTEE ON POSTWAR MEDICAL SERVICE
535 North Dearborn Street
Chicago 10, Illinois, April 17, 1945.

The Honorable Earl Warren
Governor of California
Sacramento, California

Dear Governor Warren:

The undersigned Committee on Postwar Medical Service, composed of representatives from the several organizations mentioned, was created two years ago for the purpose of giving consideration to many medical problems which will arise as a result of the war and the demobilization which will follow.

Of particular interest to the Committee at the moment are the provisions of Public Law 346, 78th Congress (The G. I. Bill of Rights) as they may affect the entire field of medical education.

The Governor of each State, as you doubtless are aware, is vested with the power and duty of certifying to the Veterans' Administration the institutions in his State which are qualified to give acceptable courses of education and training in each of many categories.

The field of medical educations, in its broadest sense, embraces (a) premedical education, (b) undergraduate education, (c) postgraduate education, (d) nursing education, and (e) the education of medical technicians. There have been developed high standards of premedical education as well as undergraduate medical education. Medical schools are classified according to these standards. Similarly, there are well recognized standards in dental education and in nursing education. There should be little difficulty, therefore, in reaching decisions concerning institutions giving instruction in these fields.

This is true to a lesser extent with respect to the

postgraduate education and training doctors receive in hospitals and with respect to schools for the education and training of medical technicians. It is true that many hospitals have been approved for intern and resident training and for the training of medical technicians in some fields. This approval is based on the number of beds and other facilities available in a hospital for teaching and the type of educational program carried on by the staff of the institution.

The importance of maintaining educational standards which are commensurate with the progress that has been made in the fields of medicine, dentistry and nursing must be obvious to you. The maintenance of these standards is in the public interest because they determine the quality of medical, dental and nursing care the public will receive.

It seems appropriate to suggest to you that certain schools which have thus far failed to secure approval will make effort to participate in the tuition payments under the G. I. Bill of Rights by having their names placed on the list of approved institutions which the Governor will send to the Administrator of Veterans' Affairs. Such schools may be schools of the medical cults. These should be approved only after they thoroughly establish their ability to give a creditable course in the several subjects embraced in the basic sciences which are mentioned in the basic science laws in effect in most states.

The Committee on Postwar Medical Service is keenly aware of the difficulties which will face the Governor in the administration of this Act. We are aware, also, of the pressure which will be brought to bear on you to obtain your approval of institutions which are not qualified and equipped to give acceptable courses of education and training in these several fields.

The Committee, therefore, begs leave to recommend that the Governor appoint an advisory committee composed of persons qualified to advise him with respect to the quality of education and training given by institutions in his State in the fields of medicine, dentistry, nursing and medical technology, which includes x-ray technicians as well as laboratory technicians.

The Committee wishes to assure the Governor that the facilities and information in the hands of the Committee on Postwar Medical Service are available to him for whatever purpose he may wish to use them, and that we shall be glad to coöperate with him to whatever extent he may wish in the solution of these difficult problems.

Very respectfully yours,

COMMITTEE ON POSTWAR MEDICAL SERVICE

Ernest E. Irons, M.D., *Chairman*
H H. Shoulders, M.D., *Secretary*

Irvin Abell, M.D.	E. L. Henderson, M.D.
Arthur W. Allen, M.D.	W. W. Herrick, M.D.
Walter L. Bierring, M.D.	Victor Johnson, M.D.
Francis G. Blake, M.D.	B. R. Kirklin, M.D.
Capt. E. L. Bortz, (MC) USNR	Lt. Col. H. C. Lueth
	James M. Mason, M.D.
Francis F. Borzell, M.D.	Col. Hugo Mella
C. Willard Camalier, D.D.S.	James E. Paullin, M.D.
Frederick A. Coller, M.D.	George Morris Piersol, M.D.
Mr. Graham L. Davis	Col. George M. Powell
Harold S. Diehl, M.D.	Brig. Gen. Fred W. Rankin
Warren F. Draper, M D.	Rev. A. M. Schwitalla, S.J.
Capt. W. E. Eaton, (MC) USN	Leroy H. Sloan, M.D.
	Mr. Barry C. Smith
Morris Fishbein, M.D.	Miss Mary Switzer
Lt. Col. G. R. Gessner	Olin West, M.D.
Evarts A. Graham, M.D.	R. C. Williams, M.D.

Fred C. Zapffe, M.D.

Casualties in March on Rhine, 47,023

Washington, April 19 (AP)—The battle for the Rhine and crossing of the river in March cost U.S. Army ground forces 47,023 casualties, Secretary of War Stimson reported today.

This total was larger than in February, when there were 34,468 losses, Stimson pointed out that it was smaller than for any month since October.

The March casualty figure included 6,214 killed, 35,448 wounded and 5,366 missing.

473,215 Since D-Day

Since D-Day last June, Stimson disclosed, American ground casualties on the Western Front totaled 473,215 up to the end of March.

At the same time, Stimson disclosed that Army casualties in all theaters reached 813,870 on the basis of names compiled in Washington through April 7. Added to the Navy's losses of 98,608, this put aggregate casualties since Pearl Harbor at 912,478, an increase of 13,088 since last week's report.

Stimson said that while current casualties on the Western Front are not yet available, they are "not high." In contrast, he said, more than 900,000 Germans were captured in April and the number of enemy killed and wounded has been high.

Huge Prisoner Bag

Since the landings in France last June, he added, Allied forces have taken well over 2,100,000 prisoners.

A breakdown on total Army casualties: Killed, 162,505; wounded, 496,803; missing, 83,926; prisoners, 70,636 and 67,514. Of the wounded, 261,596 have returned to duty.

Similar figures of Navy losses: Killed, 38,035; wounded, 45,725; missing, 10,589; prisoners, 4,259.—San Francisco *Chronicle,* April 20.

Churchill Says British Casualties Total 502,396

London, April 10 (AP)—British armed forces suffered 502,396 casualties, including 216,287 dead, up to Feb. 28, Prime Minister Churchill told Commons today.

In addition 183,242 servicemen from the United Kingdom either are prisoners of war or internees in neutral countries, he said.

These figures do not include the deaths of members of the armed forces from natural causes or casualties of civilians or merchant seamen due to enemy action.

Churchill listed Canada's losses at 89,220, including 31,439 killed, 45,251 wounded and 8,367 prisoners, and Australia's at 87,256, including 18,430 killed, 35,595 wounded and 25,276 prisoners.—Los Angeles *Times,* April 11.

Jap War Dead Top 865,000

Washington, April 10 (AP)—More than 865,000 Japanese soldiers and sailors have died for their emperor since they went to war with the United States and Great Britain. Untold thousands more have died in China.

A study of reports, based on actually counted dead and on estimates, shows the enemy has lost 603,500 killed in land campaigns, including troopships sunk, and 262,000 navy dead.

American dead in all theaters were reported last week at 156,471 for the Army and 36,649 for the Navy.

The biggest Japanese toll has been taken in the Philippines campaign, where the dead now stand at more than 314,000. Fighting in Burma has accounted for an estimated 125,000.

Major Vogel Addresses PT Graduates

Major Emma E. Vogel, PT, Director of Physical Therapists, Office of The Surgeon General, addressed the graduating class of physical therapists who received their commissions as Second Lieutenants at Walter Reed General Hospital this month. In telling about her recent inspection trip in the European Theater, she said, "It is my belief that the most important function of physical therapists in our overseas hospitals is to demonstrate to the medical world the value of early exercise and static contraction of muscles to prevent atrophy and deformity."

Educational Opportunities for Army Doctors

Since the start of World War II, over 6,000 selected medical officers have been graduated from short but intensive courses given by the Medical Department in some thirty critical medical and surgical specialties, according to Major General George F. Lull, Deputy Surgeon General. In addition, refresher courses in general medicine and surgery provide medical officers with a chance to "brush up" before returning to professional assignments after other duty.

Many doctors also benefit while in service from working under key professional personnel in military hospitals. Other medical officers who have been on duty with combat troops in the field are given an opportunity to brush up on their specialty through the rotation policy.

General Lull reported that 50 doctors have been reassigned from field to hospital duty during the past year in the Mediterranean Theater and "the merit of intra-theater rotational plans has been pointed out to other theaters, and is being encouraged in order that the maximum number of doctors might receive refresher training while they are still in military service."

Naturally, professional training of medical corps officers during military service must be restricted to meet military rather than civilian requirements. However, General Lull said, The Surgeon General is keenly interested in the welfare of these doctors and will provide "insofar as is possible" opportunities for professional training.

In the post war period, he added, all doctors will be entitled to professional training, after their release from service, under the G. I. Bill of Rights, and those who remain in the Army will have the opportunity for refresher training at selected military hospitals and civilian schools.

More Medical Administrative Officers Graduated

The seventeenth class of officer candidates, composed of a selected group of enlisted men from the Medical Department, was graduated from Carlisle Barracks last month. The graduates won their commissions as Second Lieutenants in the Medical Administrative Corps on the basis of merit and outstanding performance of duty. Immediately after the exercises they left to take over their administrative duties, thereby relieving medical and dental officers for professional duty.

Horner's Syndrome. — The Swiss ophthalmologist, Johann Friedrich Horner, was at once a leading practitioner and teacher in his chosen profession. One of the pupils of von Graefe, he followed in the footsteps of the master, adding to the greater knowledge and more effective treatment of eye diseases. In 1869, he published an article "Concerning a Form of Ptosis," which comprised one of the discoveries in internal medicine in the first half of that century.—Warner's *Calendar of Medical History.*

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Wartime Graduate Medical Meetings in California

The *Bulletin* of the Wartime Graduate Medical Meetings of April 15, lists the following meetings for Regions 23 and 24:

* * *

Region No. 23 (Nevada, Northern California)—Dr. S. R. Mettier, Chairman; Dr. E. H. Falconer, Dr. D. N. Richards.

Letterman General Hospital, San Francisco, California:

April 21—Psychosomatic Medicine—Dr. Karl Bowman.

At recent sessions at this hospital, Drs. Francis Chamberlain, Herbert F. Traut, Theodore L. Althausen, Leon Goldman, Earl R. Miller, William J. Kerr and Paul M. Aggeler have appeared on the programs.

Station Hospital, Hamilton Field, California:

May 2—Early Postoperative Ambulation of Surgical Patients—Dr. H. Glenn Bell.

May 9—Peripheral Nerve Injuries—Dr. Howard A. Brown.

May 16—Fractures of the Extremities—Dr. Carl Anderson.

May 30—Diagnosis and Treatment of Arthritis—Dr. Stacy R. Mettier.

Station Hospital, Camp Roberts, California:

April 21—Psychosomatic Medicine—Dr. Douglas G. Campbell.

May 19—Diagnosis and Treatment of Arthritis—Dr. Hans Waine.

May 26—The Treatment of Poliomyelitis—Dr. Henry D. Brainerd.

Station Hospital, Chico Army Air Base, California:

April 19—Diagnosis of Deficiency Diseases—Dr. James F. Rinehart.

April 26—Newer Methods of Treatment of Heart Disease—Dr. Francis Chamberlain.

On March 22, Dr. William J. Kerr discussed "Peripheral Vascular Diseases" before the medical officers of this hospital.

Station Hospital, Fort McDowell, Angel Island, California:

April 27 — Changing Trends in Syphilotherapy — Drs. Norman N. Epstein and Rees B. Rees, Jr.

Station Hospital, Stockton Army Air Base, California:

May 16—The Treatment of Syphilis—Dr. Norman N. Epstein.

May 30—Use and Misuse of Endocrine Preparations—Dr. Ernest W. Page.

Hammond General Hospital, Modesto, California:

April 18—Subject to be announced—Dr. Donald R. Smith.

May 30—Laboratory Aids in the Diagnosis of Disease—Dr. Jesse Carr.

"Resection of the Colon in Cancer, Colitis, Etc.," was the title of Dr. Leon Goldman's presentation on April 4 at this hospital.

Drs. Henry D. Brainerd, Albert H. Rowe and Alexander Simon took part in March programs at the Station Hospital, Camp Stoneman, California and DeWitt General Hospital, Auburn, California.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Region No. 21 (Southern California)—Lt. Comdr. G. C. Griffith, Chairman; Capt. H. P. Schenck, Dr. J. F. Churchill, Dr. W. A. Morrison.

Station Hospital, U. S. Naval Air Training Station, San Diego, California:

April 20—Treatment of Syphilis with Penicillin—Major Paul Recque.

A.A.F. Regional Hospital, Santa Ana, California:

April 17—Surgery of the Traumatic Abdomen—Dr. Charles Phillips and Commander Gaylord Bates.

Station Hospital, March Field, Riverside, California:

April 17—Blood Plasma and Blood Substitutes—Lieutenant-Colonel R. M. Jones.

Water Balance—Major Edward Schwartz.

On March 6, Dr. Paul M. Hamilton spoke on "Treatment of Acute Infectious Diseases," at the Torney General Hospital, Palm Springs, California, in place of the previously announced program.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Hospital Construction Possible Through Federal-State Coöperation

If A.B. 600 is passed by the California Legislature it will authorize the State Department of Health to take the necessary steps to establish California's eligibility for benefits under the proposed Federal Hospital Construction Act—S. 191. (*Newsletter*, Feb. 1, 1945, page 2.) The need for new or renovated hospitals and health centers will be determined by a survey conducted by the State Department. Construction, with the aid of Federal funds, would begin after approval of the State Department's construction plan.

At the present time many counties and communities, particularly those in rural areas, are unable to support and maintain adequate facilities. S.B. 183 and S.B. 586 would allow for the formation of *hospital districts*. Such districts need not conform to county lines but might embrace a portion of one county or several counties depending upon population and financial resources. This procedure has been recommended by the American Public Health Association with respect to establishing district health departments rather than the present county units sometimes staffed by part-time personnel.

The Washington State Legislature has already passed similar bills. These and other health measures have been co-sponsored in Washington State Legislature by the Joint Junior Lobby, the State Department of Health, and the Union Labor Family Medical Care Committee.—Item from the *"News Letter"* of the Northern California Union Health Committee, issue of April 12, 1945.

Increase of Rate of Pay to Nurses and Other Hospital Employees

(COPY)

LUTHERAN HOSPITAL SOCIETY OF SOUTHERN CALIFORNIA
1414 South Hope Street
Los Angeles 15, California, April 16, 1945.

To the Members of the Attending Staff:

We have found it necessary in connection with the request from the nurses' organization, and in conference with the hospitals in Southern California, to increase the rate of pay of nurses and other employees. This basic increase for nurses will be $15.00 per nurse per month, which we expect governmental regulations to approve.

Last year our payroll for the Society totaled $1,548,000.00 and with the present increase, the 1945 payroll will be more than $2,000,000.00.

It is, of course, self-evident that these increases must be passed along in new rates to the patients. We are, therefore, announcing the following rate changes at the California and Santa Monica Hospitals to be effective on all admissions after April 23, 1945:

Rates will increase ward service by 50 cents per patient per day.

Rate increase in semi-private and private rooms by approximately $1.00 per patient per day.

We also wish to announce that as soon as our costs decrease, a corresponding decrease will be made in the rates to the patients admitted. Even with these increases, we want to state that patients will be accepted on the basis of their economic status regardless of the basic rate structures in the institutions. Therefore, if you have any patient who you feel justifies lower rates than the schedule, this information should be transmitted to the Admitting Department, and such patients will be interviewed by our Social Service Workers and an equitable rate established in accordance with the ability of the people to pay. We also wish to reëmphasize that these newly announced ward rates are on the same basis as our previous ward rates; that is, the rates are less than the cost of service. These rates are only possible by spreading the cost between private rooms and wards, and the private room patient actually assists in paying for ward accommodations.

Thanking you for your coöperation, we are,

Very truly yours,

LUTHERAN HOSPITAL SOCIETY OF SOUTHERN CALIFORNIA
Ritz E. Heerman,
Assistant Secretary and General Manager

(Note.—Concerning the above, a decision from a Federal Board later forbade the proposed changes in wage schedules. Old schedule therefore remains in operation.)

Board of Managers for Southern Pacific Hospital

Creation of a 13-member Board of Managers to manage the Hospital Department of Southern Pacific, with seven members to be selected by the employee-contributors and six by the carrier, is provided for by an award in San Francisco March 2 of a six-man arbitration board. The award became effective May 1, 1945.

The award is the outcome of an arbitration agreement entered into in 1944 by Southern Pacific Company and employees represented by 15 railway labor organziations, under provisions of the Railway Labor Act.

The railroad named as arbitrators L. B. McDonald, vice-president in charge of operations, and J. G. Torian, manager of personnel; the employees named M. H. Barney, vice-president, Order of Railway Conductors, and G. E. Leighty, vice-president, Order of Railroad Telegraphers; and the National Mediation Board named the Hon. Leif Erickson, former Associate Justice of the Montana Supreme Court, and Col. Grady Lewis, U. S. Army (retired), of Washington, D. C.

Hearings extended between January 24 and February 20 and included a visit to the Southern Pacific General Hospital at San Francisco. One of the questions involved creation of a Board of Managers upon which employees would have representation. Under the award six employee representatives will be selected by the 15 organizations which participated in the arbitration proceedings and the seventh by 14 organizations not appearing in the proceedings. The company will select six. Members will serve three-year terms.

"The Board of Managers," the award provides, "shall have general power to manager the business and financial affairs of the Hospital Department, including, in particular, the power to adopt and amend the Hospital Department rules, and to increase or reduce the scale of individual employee contributions. The Board of Managers shall not have the power to impose upon the carrier, or incur in its behalf, any financial or other obligation.

"The carrier shall appoint the chief surgeon, subject to the approval of the Board of Managers. The chief surgeon shall have the supervision and control of the professional services afforded by the Hospital Department. He shall appoint and fix the compensation of all physicians and surgeons subject to the approval of the Board of Managers and from time to time shall make and promulgate such rules and regulations as may be deemed necessary for the efficient government of the physicians and surgeons and the hospitals of the department and as shall be approved by the Board of Managers."

The award ruled against appointment of a full-time salaried representative of the employees having generally the duty of presenting complaints regarding service and hospitalization.

The award provides "the carrier shall pay to the Hospital Department for hospitalization of all on-duty injury cases a sum equal to one-half the total cost of all hospital and medical care furnished by the Hospital Department in treatnig on-duty injury cases."

Southern Pacific's Hospital Department is the oldest railroad hospital department in the United States. It was esablished in 1867.

(An item concerning the above also appeared in California and Western Medicine, for March, on page 140.)

* * *

Railroad Brotherhoods in Fight for Representative Hospital Administration

Seven men, representing 80,000 organized workers employed by the Southern Pacific, are to sit as a majority of the Southern Pacific Hospital Board of Managers. This was established in a recent decision of the Board of Arbitration in San Francisco. Responsibility of these representatives includes authorization to amend hospital rules, to determine employee contribution to the plan, and to pass on the appointment of the chief surgeon and his staff. Six of the union representatives are to be chosen from the fifteen Railroad Brotherhoods who sought a settlement of their grievances against the Southern Pacific, and the seventh member is to be chosen from fourteen other organizations comprising Railroad Brotherhoods, C.I.O., and A. F. of L. locals not party to the proceedings.

Majority control was awarded by the arbiters on the principle of "No taxation without representation." Company domination has been the rule since 1868 (77 years). Employees have made compulsory payments amounting to 98 per cent of the hospital department's income, yet had no voice in policy making. The recent decision gives financial control to the employees' representatives. In the past the Company's Claims Department adjusted claims and made cash settlements on the basis of records to which only they had access. Formerly, too, the company has used the hospital facilities (supported by the employees) to care for injuries for which the company was liable. This has contributed to a hospital deficit. Now the company is ordered to pay the hospital department one-half the cost of all on-duty injuries.

The case was presented by Sam C. Phillips, Vice-President of the Brotherhood of Locomotive Firemen and Enginemen, and the major part of the factual material was prepared by the staff of the National Labor Bureau. The case has far-reaching implications, and may set a new precedent for consumer representation in existing medical care plans, a principle rarely provided for in such plans.—Item from the *"News Letter"* of the Northern California Union Health Committee, issue of April 12, 1945.

* * *

Editor's Note.—The Southern Pacific Hospital has been in operation for some 75 years, during which period many members of the California Medical Association have been on its medical staff. The changes authorized by the Board of Arbitration appointed by Federal authorities are of interest to physicians. In addition to the above news clipping, the Editor has been able to secure the following information from various sources:

* * *

The hospital department of the Southern Pacific has been operated as a bona fide department of the company since 1868. It is true that in excess of 90 per cent of the hospital department's income is derived from the employees' contributions (at present $1.75 per month for each employee, including officers). On the other hand, there have been many years in which the department's income has not equaled the expenses, and the deficit has been made up by the Southern Pacific Company. Surpluses which may have accrued in other years have not been used to repay or return these advances, but have been used to improve the hospital facilities and plant. The Southern Pacific Company owns all of the hospital facilities and has always assumed the financial, legal, and, in fact, all responsibilities of the department.

Under the award by the Board of Arbitration, the newly formed Board of Managers, consisting of seven representatives of the employees and six appointed by the company, will manage the affairs (excluding, however, anything to do with medical or professional activities) of the department. They are without authority to commit Southern Pacific Company to the expenditure of any money or other services.

The award does require the Company to pay one-half the cost of hospitalization of on-duty injuries, and sets forth the formula for computing the cost of hospitalization. Heretofore the Company has been paying the hospital a blanket sum of $60,000 per year which, in addition to other free services furnished by the Company, it has been felt compensates the department for the care of on-duty personal injuries for which the company may be entirely liable.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

NFIP Appropriates $1,267,600 For Expanded Physical Therapy Program

A critical shortage of qualified physical therapists which endangers the proper care of infantile paralysis victims has led the National Foundation for Infantile Paralysis to sponsor one of its largest projects. It involves an appropriation of $1,267,600 for the training of these vitally needed specialists and has just been approved by our Board of Trustees, subsequent to approval by the Committee on Education and the General Advisory Committee at the recent semi-annual medical meeting.

Pointing out that present day medical treatment of

patients with infantile paralysis demands more and more physical therapy, President Basil O'Connor, in announcing the program, explained: "A physical therapist is a technician who uses physical agents such as heat, electricity, light, exercise, rest, muscle training and similar methods in contrast to the use of drugs, biological and surgical techniques.

"Today there are only 2,500 qualified physical therapists, of whom more than half are in the Armed Forces. With earlier and more extensive use of such methods of treatment, so imperative in the treatment of infantile paralysis, twice the number already trained could be used for this disease alone. It is estimated that an additional 5,000 could be used right now, not only for the treatment of infantile paralysis, but also for aiding recovery from many other diseases and disabilities."

The $1,267,600 program developed under the guidance of a special committee established in the field of physical therapy consists of three parts:

(1) $1,107,000 for scholarships to train new physical therapists.

(2) $82,000 for fellowships to provide additional teachers and,

(3) $78,600 for general development of the field of physical therapy. . . .

Preparation for entrance into approved schools of physical therapy requires graduation as a nurse, or physical educator, or two years' college training including biology and other basic sciences. Applications for scholarships should be made to the National Foundation or to the American Physiotherapy Association, 1790 Broadway, New York 19, N. Y.

"Outlook for Women in Occupations in the Medical Services"

The heavy wartime demand for trained therapists has led the Women's Bureau of the United States Department of Labor to bring two brochures off the press. Bulletin 203 No. 1 is captioned "Physical Therapists"; Bulletin 203 No. 2 has title, "Occupational Therapists." Copies of the bulletins may be secured by writing to the Director of the Women's Bureau, Frieda S. Miller, U. S. Department of Labor, Washington 25, D. C.

Unionizing Attempts Agitate Nurses Here

The subject of unionizing registered nurses, a potentially lucrative promoters' field in view of the 6,000 or 7,000 registered nurses in the Los Angeles area, is again agitating the profession here.

Higher pay, shorter hours, organized resistance to drafting nurses for service with soldiers and others in armed duties and other such subjects are said by some of the nurses to be principal topics for discussion among the union promoters.

In one large hospital particularly, unionization became so much a time-consuming topic of discussion among nurses and other hospital employees that there was concern because such institutions today already are heavily burdened with work under abnormal conditions created by the war.

Both C.I.O. and A.F.L. organizers are working the field. The C.I.O. State, County and Municipal Employees claims jurisdiction over nurses in the hospitals but its promoters have not been in any recent special campaign among the nurses, according to its leaders.

A.F.L. Registered Nurses' Union promoters have been more active. They began last fall to hold quiet meetings to which certain nurses were extended a "special" invitation with a request to bring 10 others. This plan has been extended and many nurses have gone to such conclaves in Studio Carpenters' Hall, which now has become more noted as the headquarters for the current motion picture strike.

This union claims to have made some progress, after five years of work, but has not as yet accumulated enough member strength to force a contract with any of the principal hospitals here.

Some of the union promoters particularly attack as ineffectual the California State Nurses' Association, which has some 14,000 members and has been authorized to deal collectively for nurses in hospitals. Pro-association nurses meet this charge by declaring that the association is doing everything that can reasonably be done at this time but that it disdains to make use of rosy-hued promises to enlarge its dues-paying membership or to combat competition from hired union organizers.

The whole subject has become a lively and agitating topic not only among hospital nurses but also among private nurses who also are sought as union members.— Los Angeles *Times*, April 6.

C.M.A. CANCER COMMISSION

Cancer Control

Continued progress is being made in the control and eradication of cancer, one of the major causes of death among the American people. Scientific research, which has provided effective means for diganosis and treatment, in early stages of the disease, may be expected to produce even more benficial results.

One of the big needs is to educate the public to the importance of early discovery of cancer. That is the purpose of the late President's proclamation, calling for the observance during April of Cancer Control Month.

In its early stages, the disease can usually be eradicated, but when the growth is permitted to continue, control becames more difficult and frequently impossible. Medical examination at periodic intervals is a wise precaution.

Cancer Control Month is a good time to have such a periodic checkup. — Editorial in San Francisco *Call-Bulletin*, April 16.

Cancer Fund Drive Starts

A drive by the Northern California finance committee of the American Cancer Society to raise $150,000 in the San Francisco Bay Area to war against one of America's most dreaded diseases was gotten under way on April 16, at a dinner in the Rose Room of the Palace Hotel.

Speakers at the meeting, open to the public, included J. L. Neff, executive director of the American Cancer Society of New York; Dr. Ray Lyman Wilbur, chancellor of Stanford University; Lieut. Comdr. David A. Wood of Oak Knoll Hospital; Dr. James F. Rinehart of the State Department of Health and University of California, and Health Director Geiger.

J. W. Mailliard, Jr., chairman, pointed out that 50 per cent of the money which will be sought in a letter campaign wlil be expended directly in the Bay Area while the remainder will be used nationally for research and education. He said the total sought nationally is five million dollars.

Cancer Month

President Roosevelt has proclaimed the month of April "Cancer Control Month" and during this period the American Cancer Society is sponsoring a campaign to

raise a $5,000,000 fund for research and to educate the public.

Need of such public education about this disease is shown by a recent Gallup Poll. This indicated that about two adults out of five are uncertain as to what type of disease cancer really is. Almost as many believe that cancer is incurable. Only about half of the people have any idea of the symptoms, very few could even guess as to its cause.

For a number of years the Cancer Association has been attempting to educate the public, and to implant the knowledge that, taken in time, cancer can be cured. They have been urging that a doctor should be consulted about any unusual growth or blemish on the skin. The campaign has brought results, the Gallup Poll showing that whereas in 1940 only 38 per cent of the people knew the symptoms, today 43 per cent of them do.

Cancer results in a greater number of deaths each year than does the present war. Anything that will reduce that loss and intense suffering which it brings, should have strong support.—San Jose *Mercury-Herald.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

San Francisco Proposed as a Global Health Base

Dr. J. C. Geiger, director of public health in San Francisco, recently outlined a postwar international immunization program to control the spread of communicable disease from one country to another which he believes will be adopted by the nations of the world.

International air transport, Dr. Geiger said, will present new problems of health control. As San Francisco is expected to be one of the major airports of the world, he suggested that one of the proposed international health centers be established here.

"Germs don't recognize borders," Dr. Geiger reminded, "and, with airplanes traveling from one country to another within a matter of hours, the need for an international public health system of coöperation becomes of prime importance.

Dr. Geiger outlined such a plan with the following five suggestions:

1. A public health intelligence system should be set up to act as a clearing house for information concerning world public health. This could be done by organizing public health centers in key locations such as Singapore, Moscow, London, New York and San Francisco. Through these centers information concerning diseases and epidemics prevalent in all areas could be relayed and recorded.

2. An international health law should provide for adequate disinfection and spraying of airplanes before leaving infected areas.

3. Ships should be rat-proofed before leaving port. They should also be provided with epidemologic intelligence, which would radio important medical information ahead to any port of destination before the ship arrives.

4. The public should be made to realize that there is such a thing as an immunization program against disease, and be required to observe its regulations.

5. The traveler should be given educational training on diseases prevalent in the various countries which he may visit and be cautioned in methods of avoiding such diseases or immunized against them.

"There is no reason," Dr. Geiger concluded, "that the immense knowledge gained by doctors and men of science on the control and cure of disease during wartime can't be pooled in peacetime."

"Eye" Bank for Blind Formed

Formation of the eye bank for Sight Restoration, Inc., a national organization which will collect and preserve corneal tissue from human eyes for transplantation to blind persons, was announced in New York on April 13.

The bank, which hopes to aid from 10,000 to 15,000 persons in the United States now blind with corneal defects, has been incorporated under the laws of New York State and twenty-two leading hospitals in New York City are affiliated with it.

Stanley Resor, president of J. Walter Thompson Company, advertising firm, has been elected president of the eye bank. Albert G. Milbank, president of the Milbank Memorial Fund, is chairman of the advisory council.

Famous Scenes in American Medical History

Some of the most celebrated and dramatic scenes in the history of American medicine were recently placed on exhibition in oils at the Enoch Pratt Library in Baltimore. Dean Cornwell, noted American muralist and genre painter, and member of the National Academy, is exhibiting the series of paintings he has executed to date for the "Pioneers of American Medicine" series for Wyeth Incorporated, well known drug concern of Philadelphia.

The exhibition records on canvas in faithful detail colorful events in American medicine which have gone down in history as marking another step forward in man's fight against disease and suffering.

As in the other arts and professions recognition was slow in coming to the American physician and surgeon for his contributions toward the advancement of medical science and knowledge, due to dependence on the great European universities and institutions. But beginning with the middle of the last century, American medicine and surgery began to make their influence felt throughout the world through the work of such celebrated pioneers as Dr. William Osler, who helped to establish Johns Hopkins University; Dr. Ephraim McDowell, father of abdominal surgery; Dr. William Beaumont, whose recorded observation of the action of the processes of the stomach during digestions is now a classic; William Proctor, Jr., father of American pharmacy; Major Walter Reed, who proved in a series of dramatic experiments that the female mosquito was the carrier of the dread disease, yellow fever; and others.

"The Dawn of Abdominal Surgery" shows Dr. Ephraim McDowell, then an unknown Kentucky surgeon, at that tense, dramatic moment as he prepared to perform an abdominal operation on Jane Todd Crawford to remove a large tumor. Dr. McDowell's reputation—and life—were at stake, for never had such an operation been successful. Outside the operating room a group of sullen townspeople milled, shouting threats should he fail. His success, and the path his stirring achievement blazed toward the development of abdominal surgery, provided the inspiration and motif for Mr. Cornwell's celebrated painting.

In the canvas, "Osler at Old Blockley," Mr. Cornwell has depicted the great and benign Dr. Osler during the period when he worked and taught at the Philadelphia General Hospital. The painting catches an inspiring phase of Dr. Osler's genius—his remarkable ability to inspire his students.

In "Beaumont and St. Martin," Mr. Cornwell has recorded one of the truly great and dramatic moments in American medical history—the intrepid Dr. William Beaumont studying the digestive processes through a hole in the stomach of one Alexis St. Martin, who had suffered a gunshot wound which had failed to heal. The patient submitted to protracted and careful experiments

by Dr. Beaumont which resulted in the first reliable information on digestion.

Other canvases in the series by Mr. Cornwell are, "The Father of American Pharmacy," a study of William Proctor, Jr., whose contributions to the profession of pharmacy are worldwide; and "Conquerors of Yellow Fever," a group portrait of the heroic band of men who risked their lives to determine the cause of yellow fever.

Dental Care

Good dental care should be made available to all children, everywhere in the country, regardless of family income, and to that end, Federal funds should be provided the Children's Bureau of the U. S. Department of Labor for use as grants to the States for development of such a comprehensive service. This recommendation, along with others put forward at a conference on dental care for children, in Washington, was recently reported by Dr. Martha M. Eliot, Associate Chief of the Bureau.

Attending the conference were outstanding men in the dental profession from private practice, dental schools, and the public-health field, and with them, representatives of allied professions including pediatricians and physicians specializing in nutrition.

As projected by the conference, dental services for children would be developed by the State health departments under a grant-in-aid program through funds made available by the Children's Bureau as part of the over-all program of health services for children. Care might be given through schools, hospitals, health centers and clinics, and in private offices. In remote areas, trailer clinics could be used.

Diphtheria Outbreaks in Europe

During the last three years, diphtheria has broken all bounds in Northern and Central Europe and thus become the leading epidemic disease, according to the Epidemiological Information Bulletin No. 4 issued by United Nations Relief and Rehabilitation Administration's (UNRRA) Health Division. Fifteen years ago diphtheria was at about the same level all over Europe. Up to 1940 it was steadily reduced in most countries, but in Germany it began to increase. From 49,000 cases in 1927 the number of cases reported in the original territory of the Reich increased to 238,400 in 1943. In Norway, on the contrary, there were only 17 cases during the last six months before the German invasion.

The reduction of diphtheria among most of Germany's small neighbors had been brought about without systematic immunization, and the population was therefore not properly protected. This situation was all the more dangerous since a virulent type of diphtheria, not yielding to serum treatment had spread in Germany. From 3.5 per cent in 1938 the proportion of fatal cases rose to over 6 per cent in 1943. Cases among adults became frequent, and diphtheria appeared in the German army even as a fatal complication of chest wounds.

With the invasion came diphtheria carriers, and explosive epidemics soon appeared in Norway, the Netherlands, Belgium, northern France and Czechoslovakia. In the course of the three last years, there have been nearly 50,000 cases in Norway, and about 150,000 cases in the Netherlands, which has three times the population of Norway. In the Netherlands, death from diphtheria now runs barely behind the mortality from tuberculosis in spite of the increase of the latter disease. Only Great Britain and Hungary, where immunization had been pushed to the limit, experienced no rise whatever.

Socialized Medicine Perils Told

Dr. L. A. Alesen, Jr., Cites Pitfalls in Talk to District Clubs

Dr. L. A. Alesen, Jr., past president of the Los Angeles County Medical Association, admits the public health system of the United States and the medical care given its citizens are not perfect.

However, he insists that since it has increased the life expectancy of citizens some 20 years since 1880, it has exceeded anything accomplished by socialized medicine systems long practiced in Great Britain and Germany.

"There are those who now insist that we must look to the government for all medical care," Dr. Alesen told the Los Angeles District Federation of Business and Professional Women's Clubs recently.

Taxes Would Mount

"That means that we should put medicine under control of political bureaus and that costs under proposed legislation to this end would mount to $12,000,000,000

(COPY)

Los Angeles City Health Department

THE TEN LEADING CAUSES OF DEATH IN LOS ANGELES CITY, 1944

Rank	*Causes of Death*	*Number of Deaths*	*Per Cent of Total*	*Rate L. A. City*	*Rate 1942 U. S.*
1.	Diseases of the Heart	6,007	31.7	332	295
2.	Cancer and Other Malignant Tumors	2,597	13.7	143	122
3.	Intracranial Lesions of Vascular Origin	1,343	7.1	74.2	90.2
4.	Nephritis (all forms)	954	5.0	52.7	72.4
5.	Pneumonia and Influenza	887	4.7	49.0	55.7
6.	Tuberculosis (all forms)	845	4.5	46.7	43.1
7.	Arteriosclerosis	841	4.4	46.5	
8.	Diabetes Mellitus	433	2.3	23.9	25.4
9.	Premature Birth	421	2.2	23.3*	25.8*
10.	Motor-Vehicle Accidents	392	2.1	21.7	21.2
	Total of Above Causes	14,841	78.3		
	Total (All Causes)	18,959	100.0		

*Rates Computed on Population Basis.

It is constructive to review the major causes of death from time to time. Not many years ago, tuberculosis was the first cause of death and typhoid fever was high on the list. With the reduction in prevalence of these diseases, others, especially those of old age, are assuming a new importance. Diseases of the heart and cancer now lead the list.

It is obvious that much can be done to lower the death rate of several of these diseases. Cancer is just beginning to receive the consideration, as a preventable condition, that it deserves. Tuberculosis mortality has been reduced 50 per cent in the City of Los Angeles during the last fifteen years. It still, however, claims over 800 lives a year, more than all the other infectious diseases combined. Pneumonia mortality has dropped 47 per cent in Los Angeles in the last five years, since the advent of the sulfa drugs. Prematurity is the ninth leading cause of death in Los Angeles and demands the organized attention of the community.

per year. This is to be arrived at by a 12 per cent tax on all salaries, half of this to be deducted from the pay envelop and half paid by the employer."

That was only one phase of the Wagner-Dingell-Murray bill, now before Congress, which was discussed by the speaker. One of the dangers pointed out was the possible subsidy of medical education since 2 per cent of the entire amount, under provision of the bill, would be allotted to medical education under direction of the Surgeon General. This would make possible, Dr. Alesen said, control by the Surgeon General of all medical schools, the throttling of medical education and giving of opportunity for production of numberless "quacks."

Labor and the medical profession are anxious to get the same result, the medical care of all the people, the speaker said. They are only disagreed as to the method. The method proposed by the C.I.O., which the speaker discussed in some detail, he believes, would not achieve this end.

Two of the objections to this plan are its failure to provide any dental care, or to assure anything in the way of proper nursing for surgical cases or the otherwise seriously ill. The C.I.O. admits, he said, that it has been unable to solve these problems.

Death Rate Lower

"Lack of income does not bar people from medical care so often as people believe," Dr. Alesen said. "It has been the tradition of medicine to take care of the sick and refusals to do this because of doubt of payment of the fee are not so frequent as popularly believed. One proof of this is that our death rate for diphtheria, tuberculosis and other disease is far below that of England and Germany. While this is in part due to our better standards of living, it is also due to sound medical care and hospitalization.

"Members of the Los Angeles Medical Association, through the County Hospital, give an annual service of $15,000,000 per year at the hospital and $6,500,000 in other services," he said.

Dr. Alesen was one of the three speakers on the recent panel conducted by Dr. Paula Horn, the others discussing group plans for medical care and hospitalization.—Los Angeles *Times*.

Medical Finance

No function in society touches the life of the individual more intimately than does the medical profession. Therefore, it is imperative that the American people understand the broad problems of the American medical system.

The problem currently facing medicine and the people is, What kind of a medical system does this country want? Bills have been introduced in Congress which would place medicine and the health of the people in the hands of the Federal Government. Anxious to determine the attitude of the public on such proposals, the doctors, with typical thoroughness, sponsored a survey of opinion on the question. They found that the people have faith in the medical profession as it is now constituted, and are opposed to federal interference. They found, however, a desire for expansion of voluntary prepayment medical and hospital service plans There are thousands of these plans in successful operation, covering about fifth of the entire population. Doctors, with the coöperation of business and industries, are working to extend such plans as rapidly as possible.

This country has produced miracles because its people have enjoyed the right of voluntary action—freedom. Modern medicine, no less than modern industry, is a product of that freedom. Socialized medicine would introduce more compulsion into the life of the American people. Thus, it is not surprising to discover that they do not want socialized medicine.—San Francisco *Argonaut*, June 30.

Pulmonary tuberculosis is principally a disease of those between the ages of 15 and 45. This age group corresponds with that of the bulk of our industrial workers. This would, therefore, be particularly adapted to control by thorough industrial physical examinations followed by a sound and consistent policy of placement and medical supervision.—Wayne L. Rutter, M.D., and J. W. Dugger, M.D., *Industrial Medicine*.

Cost of Sylvatic Plague Eradication

University of California
The George Williams Hooper Foundation

To the Editor:

Your recent letter relative to the amount of money that has been appropriated from Federal and State funds to carry on the work of eradication, etc., of sylvatic plague has remained unanswered since it was difficult to obtain accurate figures. I understand that, at least during the past two years, approximately $240,000 have been budgeted and possibly spent. The amount of money which was used in previous years is not known but doubtless Dr. Halverson can furnish you with the data.

Sincerely yours,
(Signed) K. F. Meyer.

* * *

The following figures are the amounts actually budgeted by the State and Federal governments for the current biennium and the amounts requested for the ensuing biennial period:

Biennial period beginning 7-1-43 and ending 6-30-45	State	Title VI
Amounts budgeted	$150,420.00	$87,370.00
Total		$237,790.00

Actual expenditures for the first year of this biennium are somewhat under the total amount budgeted, owing to vacancies in personnel and also to the fact that no equipment was replaced.

Biennial period beginning 7-1-45 and ending 6-30-47	State	Title VI
Amounts budgeted	$168,320.00	$89,480.00
Total		$257,800.00

MEDICAL EPONYM

Stevens-Johnson Syndrome

"A New Eruptive Fever Associated with Stomatitis and Ophthalmia" was described by Albert M. Stevens (b. 1884) and Frank C. Johnson (1894-1934) of Columbia University and Bellevue Hospital in the *American Journal of Diseases of Children* (*24*:526-533, 1922). A portion of the article follows:

"During a period of three months we had the opportunity of observing two cases of an extraordinary, generalized eruption with continued fever, inflamed buccal mucosa and severe purulent conjunctivitis. . . .

. . . . No diagnosis could be made to correspond with the symptoms and course of the eruption in these two cases and no description was found of a skin condition in any degree comparable.

. . . . Here is a syndrome of dramatic onset, with fever, conjunctivitis and cutaneous eruption. The child is prostrated, the mouth and tongue are inflamed and raw, the eyelids are swollen and pus streams from the eyes. There is a course of three or more weeks of high fever, with leukopenia. The eruption, unlike any hitherto described, comes out progressively, for two weeks or more, matures

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

(For other comment re Annual Session, see page 244.)

American Medical Association. The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In May, KFAC will present these broadcasts on the following Saturdays: May 5, 12, 19, and 26.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Antibiotics:* R. T. Fisk, A. G. Foord and G. Alles show prolongation of penicillin action on IM injection by adding epinephrin (*Science*, 101:124, February 2, 1945). R. L. Libby notes stability of penicillin salts in cottonseed oil suspension and relatively persisting therapeutic blood level (0.05 units/cc.) from oral administration, even with impure samples (*Ibid.*, p. 178, February 16, 1945). Then W. M. Parkins & Co. say gelatin with vasoconstrictor adds to prolonged penicillin level after IM injection (*Ibid.*, p. 203, February 23, 1945). While C. D. Armstrong & Co. say 5 per cent dextrose is potent prolonging vehicle for IM injection (*Proc. Soc. Exp. Biol. Med.*, 58:74, 1945). C. J. H. Little and G. Lumb recommend giving penicillin orally with egg white, after dose of antacid (Lancet, 2:203, February 17, 1945) I. N. Asheshov and F. Strelitz isolate material from Aspergillus fumagatus active vs. M. tuberculosis (*Science*, 101: 119, February 2, 1945). G. Schwartzman finds amino acids antagonize penicillin action vs. gram-negative bacilli (*Ibid.*, 276, March 16, 1945). B. Puetzer & Co. finally synthesize clavacin (*Ibid.*, 307, March 23, 1945). J. Charney & Co. report antacids aid gastric absorption of penicillin (*Ibid.*, 251, March 9, 1945). J. M. Bahn & Co. produce in vitro penicillin resistant gonococci with structural changes (*Proc. Soc. Exp. Biol. Med.*, 58:21, 1945). B. F. Chow and C. M. McKee think chemical inactivation of penicillin by cysteine is due to sulfhydryl and amino groups (*Ibid.*, 177). Then there's a couple little symposia on penicillin (*U. S. Naval Med. Bull.*, 44:453-493, 1945) (*Brit. Med. J.*, 107-114, January 27, 1945, including L. P. Garrod on activity on bacteria), and a neat new brochure by Merck. When will silly secrecy on constitution be relaxed?

2. *Symposia:* Fairly comprehensive on rheumatic fever, with much on control programs (*J. Pediatrics*, 26:209-264, 1945). Interesting on sterility (*Med. J. Austral.*, 2:129-145, February 10, 1945). Anxious on deceleration of medical training program (*J. Asso. Amer. Med. Coll.*, 20:65-82, 1945). Anonymous, but well organized and illustrated are various War Dept. Technical Manuals, such as one on *Educational Reconditioning.* M. Fishbein edits one on *Medical Uses of Soap* (Lippincott, Philadelphia, 1945, $3).

3. *Books:* E. C. Crocker's *Flavor* is intriguing (McGraw-Hill, N. Y. 18, 1945). Blackwell's of Oxford have many new musts: H. J. B. Atkins' *After-Treatment* (18s, 2nd Ed., 1945); D. N. Matthews' *Surgery of Repair of Injury and Burns* (45s, 1945); R. R. MacIntosh's *Local Anesthesia* (10s 6d, 1945). Have you the seven experimental biology monographs issued by Macmillan's (60 5th Avenue, N. Y., 11)? E. Vasconcelos (Sao Paulo) writes best *Methods of Amputation* (Philosophical Lib., N. Y., 1945, $10). F. F. Chidester offers *Nutrition and Glands in Relation to Cancer* (Lee Fd. Nutritional Research, Milwaukee, 1944, $3). Harvard Press issues revised edition K. Landsteiner's classic *Specificity of Serological Reactions* (Cambridge, 1945, $5). L. H. Crisp

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

writes *Essentials of Allergy* (Lippincott, Philadelphia, 1945, $5). N. F. Conant's *Manual of Clinical Mycology* looks good (Saunders, Philadelphia, 1945, $3.50). Willaims & Wilkins offers maternal health conference on *The Abortion Problem* (Baltimore, 1945). R. Wartenberg's *Examination of Reflexes* looks helpful (Year Book Pub., Chicago 4, 1945, $2.50). R. A. Moore's Pathology also looks well (Saunders, Philadelphia, 1945, $10). A Gesell's *The Embryology of Behavior: the Beginnings of the Human Mind* is a must (Hoeber, N. Y. 16, 1945, $5).

4. *Et Alia:* Those interested in A. Aperia's important posthumous review of the kinetics of the peripheral vascular system (*Texas Rep. Biol. Med.*, 3:1, 1945) will find lots more similar material of value in the recently available *Hemodynamique et Angiocinetique* of D. M. Gomez (Paris, Hermann, 1941). E. J. Carey & Co, continue stimulating studies on ameboid motion and secretion of motor end plates in shock (*J. Neuropath. Exp. Neurol.*, 4:134, 1945). R. T. Simmons shows that most Indonesians are Rh positive (*Med. J. Austral.*, 2:108, February 3, 1945). E. H. Ackerknecht tells a pertinent story in *Malaria in the Upper Mississippi Valley*, 1760-1900 (*Suppl. 4, Bull. Hist. Med.*, Baltimore, 1945). P. O. Wolff's historical sketch of pharmacology (*Sem. Med.*, Buenos Aires, 1944) is O.K., but uses old Prolegomenon (*University Calif. Pub. Pharmacol.*, 1:1, 1938), without credit. W. Ganado discusses clinical characters of pain (*Brit. Med. J.*, 2:141, February 3, 1945). F. L. Meleney reviews prevention of infection in wounds and burns by use of sulfonamides (*SG&O*, 80:263, 1945). W. S. Hartroft and C. C. Macklin find lung alveoli average 0.025 sq mm. in area (*Trans. Roy Soc. Canada*, 3rd Ser., 37:51-81, 1944). C. A. Ross and E. J. Poth suggest traces of acrolein in oxidized cod liver oil may confer reputed antibacterial effect (*J. Lab. Clin. Med.*, 30:226, 1945).

"Outlook for Women in Occupations in the Medical Services."—The heavy wartime demand for trained therapists has led the Women's Bureau of the United States Department of Labor to bring two brochures off the press. Bulletin 203 No. 1 is captioned "Physical Therapists"; Bulletin 203 No. 2 has title "Occupational Therapists." Copies of the bulletins may be secured by writing to the Director of the Women's Bureau, Frieda S. Miller, U. S. Department of Labor, Washington 25, D. C.

San Francisco County Society Phone Service Breaks Own Record.—The all-time record for calls to the San Francisco County Medical Society's 24-hour telephone service was broken again in February.

During February, a total of 1,321 callers asked to be recommended to physicians, 803 during the daytime and 518 at night—topping by 56 the previous record just established in January, 1945.

February also saw the biggest one-day number of daytime callers—a total of 71 calls.

Continued growth of the service, now in its third year, is evidence of its value both to newcomers to San Francisco and to old-time residents whose own doctors have gone to war.

The telephone service is available day and night, every day in the year, including Sundays and holidays. Callers are given their choice of three physicians, and specialists are recommended when need for them is indicated. The number is WAlnut 6100.

The County Medical Society asks that callers have paper and pencil ready before calling, to take down names and addresses. Physicians are not dispatched to inquirers, but prospective patients must make their own arrangements with one of the persons recommended to them. For night callers, the service suggests physicians living as near as possible to the inquirer.

Society for the Prevention of Asphyxial Death.—This organization was incorporated in 1933 and its aims and purposes were approved by the American Medical Association in June of the succeeding year. The S P.A.D., with offices at 38 East 61st Street, New York 21, is a charitable organization. Concerning the work of the organziation, the *Westchester Medical Bulletin* of January, 1945, under the caption, "A Dual Problem: Asphyxia and Resuscitation" made comment. An excerpt from the article follows:

The stark reality of 50 000 deaths a year from asphyxia raises serious question as to whether our approach to this problem is thoroughly up-to-date. These deaths fall into two categories: (1) those that no plan of anticipation could offset, and (2) those that could be prevented by anticipation, education, regulation, and by the prompt and proper treatment of the patient at the time of the asphyctic emergency. It is the size of the latter group that lends support to those who argue that the challenge of asphyxia has not been met.

Responsibility for this situation is widespread; it involves professional, industrial, governmental, public health and emergency groups so thoroughly that, at present, it must be shared by all.

As in the field of Public Health the best treatment for this national "disorder" is still prevention. In this respect industry both independently and under government regulation has turned in a job that can withstand considerable scrutiny.

Berkeley Hospital Prints Interesting Brochure for Staff Members.—The Berkeley Hospital *Bulletin*, issued by the Berkeley Hospital of 2001 Dwight Way, Berkeley 4, enclosed with the issue of April 13th, an illustrated reprint from *Fortune* magazine. Explanatory statement from the *Bulletin* follows:

"U. S. Medicine in Transition."—*Fortune* magazine published an excellent article on this subject in the issue of December, 1944. It puts the question, "Will voluntary doctor-patient coöperation head off the trend toward Federal insurance?" A reprint of the article is enclosed and well merits your reading.

American Board of Ophthalmology.—The American Board of Ophthalmology will hold an examination at Los Angeles in January, 1946, at the time of the Mid-Winter Course.

Applications for this examination must be filed before September 1st.

For details, prospective candidates should write at once to Dr. S. Judd Beach, Secretary, Cape Cottage, Maine.

Memorial to Dr. George K. Rhodes.—A memorial to the late Dr. George K. Rhodes, professor of surgery on the San Francisco campus of the University of California, concerning whose death an obituary appeared in CALIFORNIA AND WESTERN MEDICINE, for September, 1944, p. 166, will be established by his friends, patients and former students, according to Dr. Glenn Bell, associate professor at the Medical School. At the time of his death, Dr. Rhodes was in Southern England, consulting surgeon of the Army's Southern Base Section. A

committee of arrangements headed by Dr. Bell will plan what form the memorial will take, depending upon the amount of money contributed.

Postgraduate Resident Training at Franklin Hospital.—Franklin Hospital of San Francisco announces that the Council on Medical Education and Hospitals of the American Medical Association has extended its approval to the Franklin Hospital for postgraduate resident training in internal medicine. The American Board of Internal Medicine has concurred in this action. Thus, Franklin Hospital is now approved for postgraduate training in general surgery, orthopedic surgery, neurological surgery, urology and internal medicine.

Bibliography of Industrial Hygiene.—The U. S. Public Health Service has recently brought off the press *Public Health Bulletin* No. 289, "Bibliography of Industrial Hygiene" to cover the years 1900-1943. The brochure is a selected list compiled by representatives of the Industrial Hygiene Division of the Bureau of State Services. Copies may be obtained at 20c per copy, from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

Change in Medicines with Passing Years.—The tremendous changes in drugs over the past 35 years are recalled in the *Journal of the American Medical Association.* Selections made by a group of professors of medicine put penicillin, the sulfonamides and anti-biotics as the most important remedies developed since 1910. Other important remedies developed in that period include whole blood, blood plasma and blood derivatives; quinacrine (Atabrine); ether and other anesthetics; digitalis; arsphenamines; immunizing agents and specific antitoxins and vaccines; insulin and liver extract, other hormones and vitamins.

The ten most important drugs used in 1910 were listed by the *A.M.A. Journal* as: ether, morphine, digitalis, diphtheria antitoxin, smallpox vaccine, iron, quinine, iodine, alcohol and mercury.

Prizes for "A Plan for Improving Hospital Treatment of Psychiatric Patients."—The Modern Hospital Publishing Company, 919 North Michigan Avenue, Chicago (11), announces three prizes (first prize, $500; second prize, $350; third prize, $150) for an essay on the subject, "A Plan for Improving Hospital Treatment of Psychiatric Patients." All essays should be addressed to the Modern Hospital Publishing Company prior to October 1st. Circulars of information concerning the competition may be obtained by writing to the editor of that publication.

Surgeons Told of New Serum.—Results of research work being carried on in this country and in Russia on a new serum to improve the health standard generally by stimulating the protective functions of the body were described on April 6 by Dr. Reuben Straus, Los Angeles pathologist, at the annual meeting of the Southern California Chapter, American College of Surgeons.

The serum, identified as "ACS," has been under investigation in Russia since 1924 and in clinical use there since 1937 but Dr. Straus said that in this country "our experimental work is far from complete and it would be unfair to make a statement of any sort now." He promised, however, a full report on the serum "when the evidence from our experiments is completed."

Anesthesia Discussed

More than 200 Southland surgeons assembled for the all-day sessions at the Los Angeles County Medical Association Building. The morning section featured a panel discussion of anesthesia, with Dr. Donald G. Tollefson, president of the chapter, presiding. Dr. Harold L. Thompson presided at the afternoon session, at which a number of papers on various surgical problems were presented.

At the dinner meeting, Dr. George Miller of Chicago, director of educational activities for the American College of Surgeons, told of plans to assist in providing postgraduate training for young doctors who have been in military service.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Just Plain Stupid: On Intern Training

The science department of *Time Magazine* recently published graphs illustrating a precipitous drop in the last few years in the number of Ph.D.'s granted by United States universities in four basic sciences. They were termed startling signposts on the road to "scientific bankruptcy." They reflect the shortsighted manpower policy of our government, the effects of which are already being felt seriously in the medical profession. The training of doctors has been reduced dangerously.

An unquestioned authority commenting on the inadequacy of present internship, states that: "Many institutions, in their desire to accede to the wishes of the Army and Navy, have arranged their internships so that an experience of no more than two or three months in surgery is obtained. According to the regulations, two-thirds of all the male interns—approximately 4,000—every nine months will enter active military service with, at the most, no more than a few months' experience in surgery. It is these eager but inadequately trained young officers who will serve at battalion aid stations, where the wounded are first brought and where expert surgical judgment is often needed."

No nation, if it wishes to lead the way toward a better civilization, can afford to neglect the sciences as we now are doing.—Editorial in Campbell *Press,* March 8.

They're the Country's Doctors

Standard Oil of California placed the following advertisement in the San Francisco *News* of April 23:

Take "Dr. A" of Okanogan. Last year he had a heart attack—a mean one. For anybody else his orders would be "Take it *easy!*" So he is working a 24-hour day and a 365-day year—and supervising a hospital besides.

Take "Dr. X" of Winthrop and "Dr. Y" of Brewster. They're pressing 80. Yet any "3 a.m." may find them wrestling pneumonia, racing the stork or watching a child's bedside—as they did in the horse-and-buggy days.

Thus, in wartime, the medical men of the West's smaller communities carry on as did the doctors of pioneer days—doing a marvelous best-they-can with what-they've-got.

We call them country doctors—as the most honorable of terms in the language. For—even though they practice with modern methods in modern towns—goodness gracious what a lot of country they cover!

Okanogan County is 5,295 square miles of Washington. Of the doctors left, just four have the football physique needed to absorb the punishment they're taking. And—oh, yes!—adjacent Ferry County no longer has a doctor. These four—and their selfless associates like Drs. "A," "X" and "Y"—must keep an eye on Ferry County, too.

We take Okanogan County because our branch manager, who seems to know everybody, suggested it. Any other nonurban county in a dozen western states can duplicate its heart-warming story.

Doctors have traditionally been known as hard workers. They've always taken care of everybody but themselves. So what we say won't change anything. But it's a satisfaction to recall, of every country doctor, something said by another. "Well done," it runs, "thou good and faithful servant."

Drug Discoveries

The medical profession was recently polled to determine what it considers the ten most important remedial agents now in use.

Such a poll was conducted in 1910. It is amazing to compare its results with the 1945 list.

Only three of the drugs considered most valuahle 35 years ago are still rated highly. They are ether for anesthesia, digitalis for heart disease, and quinine.

The latter, cut off when the Japanese overran the source of supply, has been largely replaced by atabrine, discovered in 1932. War in the tropics has made it so important that the U. S. Surgeon General has declared we could not operate there without antimalarial remedies.

Penicillin and sulfa drugs quite naturally lead the 1945 list. The former was first discovered in 1929 by Dr. Alexander Fleming. The sulfas were discovered as early as 1908, but their value was not recognized until the late 30's.

Both sulfa and atabrine are derived from lowly coal tar.

Use of whole blood and plasma is considered the second most valuable recent discovery. The principle was first discovered in 1871, but it was not until 1935 that the technique for its use was perfected. It has saved hundreds of thousands of soldiers' lives.

Other highly rated modern drugs are new ones useful in treatment of venereal disease, new anti-toxins and vaccines, insulin and liver extract, hormones and vitamins.

An interesting commentary on research progress is the fact tbat four drugs favored in 1910 were iron, iodine, alcohol and mercury.

One other miracle drug developed for use during the war is DDT, the insect killer. It also was discovered and rediscovered, first in 1874 and then in 1939. While it is not a remedial preparation it may prove to be a great future boon to mankind as a disease preventive.—Sacramento *Union*, March 31.

Medical School

Certificates of Completion, Curriculum in Physical Therapy, were awarded to: *Fort Bragg*—Ellen Marie Luoma; *Oakland*—Maude Moore Signa; *San Francisco*—Roberta Elaine Ceiley, Margery Stone McCullough, Mabel Dechter Melnicoe.

Certificates of Completion, Course for Laboratory Technicians, were awarded to: *Chico*—Kathryn Augusta Jaekel; *Oakland*—Gertrude Victoria Erikson; *San Francisco*—Jean Frickey, May Cecilia Lo, Rosefannie Newburgh, Charlotte Rodenbaugh.

Certificates of Completion, Course for X-Ray Technicians, were awarded to: *San Francisco*—Emily F. Bacon, Geraldine A. Garcia; *Yuba City*—Billie Avis Allen.—University of California *Clip Sheet*, April 24, 1945.

Kenny and Infantile Paralysis

Chicago, March 23.—(UP).—Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, today described as a "preposterous untruth" charges that the *Journal* "has suppressed any scientific evidence about the Kenny methods" of handling infantile paralysis.

Sister Kenny, the Australian nurse who brought a new concept of poliomyelitis treatment to the United States, asked for a congressional investigation yesterday of what she called opposition to her system of treatment.

She accused the *Journal of the A.M.A.* of publishing in pamphlet form a report unfavorable to her methods, while not publishing in the same form a valuable report. Both reports, she said, had previously appeared in the *Journal*.

Dr. Fishbein denied the accusation also. He said that the *Journal* has published papers both favorable and unfavorable with a view "to giving the medical profession actual experience and evidence, not opinion."

Sister Kenny earlier this week said she had decided to leave the United States because she believed that this country no longer wanted her work.—Pasadena *Post*, March 23.

Health Insurance for the Nation

From Washington, D. C., comes the following statement by Senator Robert Wagner for publication by Northern California Union Health Committee:

"In the last Congress, Senator Murray and I introduced a bill that proposed a broadened and strengthened social security program, including health insurance. That bill, popularly known as the Wagner-Murray-Dingell bill, received widespread attention. A revised bill is being prepared, with changes to take into account many helpful criticisms. I hope the bill will be ready for introduction in the very near future and that it will provide a useful basis upon which Congress can build a stronger system of social security for the Nation.

"There is a general agreement on the necessity for, and desirability of, a program for improving the health of our Nation. . . . Such a plan will enable the people to obtain all needed medical care through small, regular payments based on their earnings, and will give them security against catastrophic costs for which they cannot budget individually. . . .

"Propagandists against health insurance talk about 'regimentation' of doctors and patients, 'political' and 'socialized' medicine, 'lowered standards' and so on. But health insurance is *not* socialized medicine. Health insurance is simply a method of paying medical costs in advance. It is simply a method of assuring a person adqeuate medical care by eliminating the financial barrier which exists between the patient and tbe doctor.

"The legislation which I have introduced on health insurance assures free choice of physician and patient—free choice to participate in the system, or to obtain medical care oustide the system; and free choice on the part of physicians as to methods of remuneration. High standards of medical care are protected and encouraged through incentives for the professional advancement of doctors, postgraduate study, professional education, research, and the availability of consultant and specialist services, laboratory benefits and x-rays, to all, regardless of ability to pay."—Item from the *"News Letter"* of the Northern California Union Health Committee, issue of April 12, 1945.

Medical Centers

Years ago the Committee on the Costs of Medical Care advised the establishment of medical centers as part of a far-reaching program. The soundness of that advice is becoming increasingly evident. We hear more and more of medical centers—institutions in which clinicians, consultants and laboratories are clustered under one roof, with every diagnostic and therapeutic aid required in the practice of medicine and surgery. Now Surgeon General Thomas Parran of the United States Public Health Service advocates such centers in his annual report and presents us with a concrete plan. If Dr. Parran has his way, there will be a medical center, with full health service, in every unit of 50,000 population, and by "full" he means everything—even dental care, the correction of malnutrition, the treatment of the chronic diseases of old age, and nursing.

There can be no question that if we ever embark on a program of compulsory medical insurance such centers wlil be indispensable, not only to maintain the Nation in good health, but also to keep taxes within reason. But who is to practice medicine in these centers. The opposition to salaried Federal or State physicians is so formidable that legislators are willing to abide by the principle of free choice of physician, which means that the medical centers would be open to any physician who has a license and who is a member in good standing of a county medical society.

Blanket approval of a license, however, is no guarantee of good medical care. Competence should be determined by suitable standards. Unless there are such standards, medical centers, though they will do much good, will not perform tbeir function with the desired efficiency with freely chosen physicians. The alternative to periodic reexamination as a test of competence is compulsory coöperation with the medical center's staff, so that we have group practice on the Mayo plan.—El Centro *Morning Post*, February 23.

"Poet Physicians"

"Poet Physicians," by Mary Lou McDonough, is an "anthology of medical poetry written by physicians." Doctors, it seems, though scientists, have souls, and more than 100 of them have been bared by Mrs. McDonough, wife of Capt. Stephen J. McDonough, AP science writer now on leave.

Some physicians put prescriptions in rhyme so they could be memorized easily; others, perhaps tired of ailing bodies, sought relief in poetry. Their subjects include "Dissecting Room," "Paranoia," "Tuberculosis," "Before a Corpse," "The Way to Have Handsome Children."

It is to be hoped that some were better doctors than they are poets. But some could not possibly have matched in medicine their poetical achievements. Among them Oliver Goldsmith, Oliver Wendell Holmes, Francis Thompson, Keats, Smollet and among contemporaries, William Carlos Williams.—Sacramento *Union*, March 25.

Work to Start Quickly on $10,000,000 Sewer

Construction work in connection with the new sewage treatment plant and submarine outfall, toward which the

voters recently approved a $10,000,000 bond issue, will get under way within a few months, or just as soon as funds are realized from the sale of the bonds, it was announced by President Frank Gillelen of the Board of Public Works.

Gillelen said the board expects the War Production Board will grant material priorities as soon as it is satisfied that funds have been provided.

Excavation First Task

First work will consist of excavating the site for the treatment plant, Gillelen said, and award of a contract for this job probably will be the start of the giant project, which eventually will require an outlay of $21,000,000.

Gillelen said he expects favorable action by other cities in the district, which will use the sewer, in contributing $5,000,000 as their share, and the Legislature in providing $6,000,000 toward a project which is so vital to the health of the metropolitan area.

City Engineer Lloyd Aldrich estimated that under the most favorable conditions it will be two years before the treatment plant and submarine outfall are in use.

Some idea of the size of the plant, he said, may be gained by the fact that the site required is 1,400 feet wide and 4,000 feet long. This, he said, will have to be leveled and adjoining land acquired to provide for the slopes.

Another job, according to Aldrich, will be to divert the central outfall in the north outfall sewer on the Hyperion property.—Los Angeles *Times*, April 5.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Revocation of License for Conviction of Offense Involving Moral Turpitude

Business and Professions Code, Sec. 2383, provides:

"The conviction of a felony or any offense involving moral turpitude constitutes unprofessional conduct within the meaning of this chapter. The record of the conviction is conclusive evidence of such unprofessional conduct."

In *Brainard vs. State Board of Medical Examiners*, 68 A.C.A. 678, the question was presented to the Court whether a physician's conviction in the Municipal Court of violating Sec. 11225 of the *Health and Safety Code* constituted an offense involving moral turpitude, for which the physician's license to practice medicine in the State of California could be revoked. *Health and Safety Code*, Sec. 11225, makes it a public offense for anyone to administer or dispense narcotics without making a record of the transaction. The offense is not a felony.

The petitioner in the above case was duly licensed to practice medicine in this State. A complaint was filed with the Board of Medical Examiners in which it was charged that the petitioner was guilty of unprofessional conduct, as defined by the above quoted section of the *Business and Professions Code*, in that he had been found guilty of failing to keep proper narcotic records. At the hearing before the Board of Medical Examiners a copy of the record of the conviction was presented to the Board, and after hearing the petitioner's license was revoked. He thereupon filed a petition with the Superior Court for a writ of mandate requiring the Board to restore his license. It was contended that failing to keep proper records did not constitute an offense involving moral turpitude, and that this was evidenced by the fact that the petitioner was only given a suspended sentence of one day by the court, upon his plea of guilty to the charge. On appeal to the District Court from the Superior Court's denial of petitioner's application for a writ of mandate, the District Court announced the rule:

"Whether or not the offense committed did in fact involve moral turpitude depends upon all of the surrounding circumstances. The Board of Medical Examiners was not limited by the sentence pronounced by the Municipal Court, but it was justified in hearing evidence concerning all of the circumstances surrounding the offense for the purpose of determining if indeed moral turpitude was involved."

The Appellate Court reviewed the record and found that it contained ample evidence to sustain a finding of commission of an offense involving moral turpitude. A narcotic addict had been given marked money; he entered petitioner's office and the marked money was later found in possession of petitioner. The revocation of petitioner's license to practice medicine was sustained.

The contention made by the physician, petitioner in this case, illustrates the advisability of the Board of Medical Examiners considering all evidence which may be relevant in the passing upon possible revocation of the license. In the *Brainard* case, in the absence of evidence of the facts surrounding the petitioners commission of the offense of failing to keep proper narcotic records, the Board's action in revoking his license might have been reversed. Under *Business and Professions Code, Sec.* 2383, the introduction before the Board of Medical Examiners of the Court records showing conviction of a *felony* would always be sufficient to sustain a finding of unprofessional conduct. Where, however, the offense involved is only a misdemeanor, in revoking the license it is necessary that the Board go beyond the mere record of conviction and have before it all relevant facts which tend to show that the offense does involve moral turpitude The reason for this is that in the absence of a statute expressly indicating that evil intent or moral turpitude is inherent in the commission of a crime, the courts are generally reluctant to classify many crimes as involving moral turpitude.

† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning Number of M.D. Licentiates in California:

(copy)

California and Western Medicine
San Francisco, March 22, 1945.

California State Board of Medical Examiners
c/o Frederick N. Scatena, M.D., Secretary
1020 N Street, Room 536
Sacramento 14, California

Dear Doctor Scatena:

Owing to proposals that have come from the East and elsewhere that California and other States grant temporary licenses to physicians who are in military service, or who have been engaged in essential industry, I am writing to ask for information concerning the number of licentiates in California, and the accretions to the total group of licentiates year by year.

Kindly answer the following questions, if information is available. (Note. Figures given by Secretary Scatena have been inserted below by the Editor. K.)

(1) At date of March 3, 1945, there were a total number of legally registered doctors of medicine licensed to practice as physicians and surgeons 11,321. (Refers to Physicians and Surgeons, with M.D. degree, not Physicians and Surgeons, with D.O. degree.)

† California and Western Medicine does not hold itself responsible for views expressed in articles or letters when signed by the author.

(2) According to the records of the California State Board of Medical Examiners, an approximate estimate of the number California licentiates who are in military service, reaches the number of 3,600 (approximate figure).

(3) According to the records of the California State Board of Medical Examiners, an aproximate estimate of the number of California licentiates who are neither in military service, nor in active practice in California, is probably about (not available).

(4) According to the records of the California State Board of Medical Examiners, at the time of the annual accounting for State directory or other purposes, the number of Doctors of Medicine who have been legally licensed in California and who have maintained their right to practice in California through payment of the annual tax, for the following years, was:

Year	*Number M.D. Licentiates*
1920	6,242
1930	10 333
1940	12,534
1941	12,868
1942	12,512
1943	11,289
1944	11,119

* * *

The above information deals with statistics that deeply concern the problem of adequate medical practice in our Commonwealth. We will appreciate an early reply.

Thanking you for your coöperation in the above,

Cordially yours,

(Signed) George H. Kress, M.D.,
Secretary-Editor.

Concerning a Letter from Students of the University of California Medical School—Re: Maintenance of Standards in Medical Education:

(copy)

San Francisco, California, April 2, 1945.

To the Editor.—Since we feel that the status of medical education must ever be kept in mind in any consideration of a health program for the State, a number of University of California Medical students have signed a petition stating certain concrete ideas on the subject.

Knowing of your interest in the problem, we are herewith submitting a copy of the petition for your consideration.

Very truly yours,

The Petitioning Students

* * *

University of California Medical School

Petition by the Undersigned Students

Whether we believe the health insurance plans before the Legislature are desirable or not, we do believe that provision must be made for the continuation and improvement of the high standards of medical education and medical care of the University of California and other medical schools. We, therefore, believe that any bill to be considered for passage by the Legislature should include the following points:

1. That the medical schools be represented on the administration.

2. That the clinics of the medical schools be accepted and paid as practicing groups under the act.

3. That all the money for the services rendered by the Clinic of a medical school, be paid as a lump sum to the medical school for the maintenance and improvement of medical services to the people, medical research, and medical education.

* * *

This petition was signed by 106 students of the second, third, and fourth year medical classes. It was submitted to the Governor and State Assembly.

Concerning California Program for Rheumatic Fever:

(copy)

State of California
Department of Public Health
San Francisco, April 9, 1945.

C. L. Palmer, M.D., Chairman
The Medical Society of the State of Pennsylvania
Committee on Public Health Legislation
Pittsburgh, Pennsylvania

Dear Doctor Palmer:

Doctor George H. Kress has referred to this Department your inquiry regarding the California Program for rheumatic fever.

The Program here is limited to a demonstration in two Counties, Solano and Contra Costa in the East Bay area. Referrals to one of the eleven diagnostic clinics are made by practicing physicians, school physicians, public health nurses, etc., and each child is given a careful workup. Children diagnosed as having active rheumatic disease or rheumatic carditis or potential rheumatic carditis, are hospitalized and brought under active treatment and later put under convalescent care as indicated.

The enclosed copy of an article by Doctor Helen Johnson, Director of the clinics, will give you further information.

Sincerely yours,

Jessie M. Bierman, M.D., *Chief*
Crippled Children Services

Books About Doctors Draw Interest at Sacramento City Library

No profession is more exacting than that of a doctor. His work often means long hours of hard work and frequently puts him in strange situations. Very few others have the chance to battle death at such close quarters as he does.

Because of the unusual nature of his job, the doctor who chooses to write a book about his experiences commands more than average attention from the reading public. At the City Library there are many books by members of the medical profession and about them.

Outstanding is the popular American Doctor's Odyssey, by Victor Heiser, which gives a fascinating account of the author's distinguished career in the Philippine Islands, the South Seas, India, and many other foreign lands.

Other books of similar interest at the City Library are: A Surgeon's Fight to Rebuild Men, The First Woman Doctor, A Surgeon's World, A Doctor Comes to California, Ship's Doctor, The Horse and Buggy Doctor, Consultation Room, Test Tubes and Dragon Scales, Frontier Doctor, Doctor in Arabia, Doctor—Here's Your Hat, A Yankee Doctor in Paradise, The Healing Knife, Doctor of the North Country, Fifty Years a Country Doctor, A Woman Surgeon, Hugh Young; a Surgeon's Autobiography, In Search of Complications, The Winds of Circumstance, My Days of Strength, Exploring the Dangerous Trades, I Remember, Doctor at Timberline, and Behind the Surgeon's Mask.—Sacramento *Shopping News.*

America consumes 5,000,000 pounds of camphor annually; factories can produce all of it synthetically.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 5, May, 1920

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Hospital Executive," by W. E. Musgrave, M.D., San Francisco.—By whatever title—managing director, manager, superintendent, or what not—the chief executive is the most important factor in any enterprise, whether organized for hospital, social or business purposes. The title used in hospital work is of minor importance so long as it is consistent with the responsibilities of the position as one of the most difficult of specialties. "Superintendent" was an appropriate title for the head of an old time hospital as it is for the commercial "hotel for the sick" of today. It is quite inappropriate for the administrative head of the modern community srevice, educational, better health center hospital that is growing out of the present national movement. . . .

From an Article on "Clinical Observation and Treatment of 134 Cases of Chronic Prostatitis," by Lionel P. Player, M.D., and Charles P. Mathé, M.D., from the Urological Department of the University of California Medical School.—The most discouraging, as regards treatment, yet the most frequent condition encountered in the practice of Urology, is Chronic Prostatitis. After a careful study of these cases, observed for the past eighteen months, we have found that the usual methods of treatment are unsatisfactory. . . .

From an Article on "Contracture of the Bladder-Neck and Other Obstructions Thereat, Exclusive of Prostatic Hypertrophy and Cancer, and Their Treatment," by Robert V. Day, M.D., Los Angeles, Calif.—While the literature deals admirably and abundantly with pathology, symptoms, and the classic Young's Punch operation, there are quite a considerable percentage of cases which present anatomical features and technical difficulties that require separate consideration from a surgical standpoint. It is not necessary to go over the pathologic anatomy or the symptoms except to state that there is in all a bar, a tight collar or a firm, hard, fibrous non-dilatable ring. . . .

From an Article on "The Lay Anaesthetist," by Walter R. Crane, M.D.—At a recent meeting one of our members read a paper entitled "The Lay Radiographer," a paper that was clean cut and to the point, and that the radiographic situation in Los Angeles certainly called for. A similar condition exists to embarrass and lower the efficiency of the anaesthetist, and I wish tonight to call your attention to the Lay Anaesthetist, who is not licensed to practice medicine or surgery in this state. . . .

There are certain qualifications which every one who gives anaesthetics should possess. . . .

From an Article on "Report of Eye Lesions Due to Focal Infections," by Leon Wallace Mansur, M.D., Los

(Continued in Front Advertising Section, on page 14)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M.D.
Secretary-Treasurer

Board Proceedings

As announced in the last issue of California and Western Medicine, an oral examination for reciprocity candidates will be held at the Board's San Francisco office, 515 Van Ness Ave., on May 20th, starting at 10 A.M.

A written examination will be held at Native Sons Hall, San Francisco starting at 8 A.M., Monday, May 21st, and continuing through the 23rd.

Applications for either of these examinations must be received in the Sacramento office of the Board at least two weeks prior to the date of meeting.

News

"The Assembly yesterday passed a bill placing the State Board of Chiropractic Examiners in the Department of Business and Professional Standards. It now goes to the Senate. The bill, by Assemblyman Brady, San Francisco, would put the Chiropractic Board in Division 1 of the Department, in the same status as the Board of Medical Examiners, Pharmacy and Nurse Examiners. Not only the Chiropractic Board, but any other board which regulates licenses, or controls a branch of the healing arts, and which may be created by initiative in the future, would be placed in similar status." (Sacramento *Union*, March 13, 1945.)

"By a six to two vote the senate business and professions committee defeated SB. 1004, Judah, which would legally change drugless practitioners in California to drugless physicians. Senator H. R. Judah of Santa Cruz County said the drugless practitioners principally wanted the bill to enable them to perform premarital examinations. . . ." (Sacramento *Bee*, March 2, 1945.)

"Violations of State child adoption laws by doctors throughout California were charged today by Charles Wollenbreg, director of the State Social Welfare Department, discussing skyrocketing number of illegitimate wartime births. Unlawful practices . . . are being increasingly reported to the department, according to Mr. Wollenberg . . ." (San Francisco *News*, March 8, 1945.)

"Reta Brown, 18-year-old City College student, died last night on the way to a Hollywood doctor's office, after she had confessed to her mother that she had undergone an illegal operation. The sheriff's office sent out a State-wide bulletin asking officials to be on the lookout for Dr. Faye E. Cramer, 48, a male physician, of Hawthorne, on suspicion of murder. . . . Officers who went to Dr. Cramer's office in Hawthorne were told that the doctor was 'out of town for a week or so.' They said he might attempt to flee to Mexico. Sheriff's deputies said that an autopsy will be performed." (Hollywood *Citizen-News*, March 24, 1945.)

"The State Board of Chiropractic Examiners acted

(Continued in Front Advertising Section, on page 22)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



"SINCE many of the conditions obtaining among troops during war time are simultaneously factors which predispose to the endemic and epidemic spread of . . . amebic dysentery among military personnel and civilians . . . these diseases assume great significance . . . not only to the medical departments of the armed forces but to the civilian physician as well." —Lt. Com. W. L. Voegtlin, USNR: N.W. Med., 43:69 (1944)



Increased investigation into "tropical diseases" has disclosed the unsuspected prevalence of amebic dysentery in the United States.

In suspected or frank cases, and for the treatment of "carriers,"



Diodoquin

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"meets the requirements of an amebicide free from toxicity and practical for routine use . . ."*

Diodoquin — an original product of Searle Research — contains 63.9% iodine in a tasteless, oral form which is non-irritating and of negligible toxicity.

Council-Accepted. Available in bottles of 100, 500, 1000 tablets. Item No. 1168600 on the Army Supply Table.
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*Silverman, D. N.; Amer. J. Digest. Dis. & Nut., 4:281-282 (July) 1937.

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Resident Clinicians

PROMISCUOUS WOMEN ARE MAJOR FACTORS IN VENEREAL SPREAD

(Continued from Front Advertising Section, Page 28)

2. Achievement of a religious and socially moral outlook with adequate religious training of the child in his moral obligations to his God, his parents, his country and himself.

3. Establishment of a coördinated health education program in the public schools.

4. Establishment of community recreational facilities.

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6. Progressive social hygiene instruction of the child by the parent.

7. Continued social guidance to post-adolescent youth by the church and state.

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10. Active, intelligent, continuous and diligent repression of commercialized prostitution.

11. Adequate public health education regarding problems, symptoms, nature and method of prevention and treatment of venereal diseases.

12. Free diagnosis readily available for all

(Continued on Page 38)

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Of the amazing array of chemical elements and compounds present in the body, one constituent substance is found in every cell, every tissue, every secretion: protein. Though basically similar, it differs in its composition from tissue to tissue, from cell species to species.

Subject to the laws of supply and demand, it spends itself in growth, in wear and tear, and in metabolic maintenance. To regenerate itself, it has only one source of the materials needed—the proteins contained in the foods eaten.

Among the protein foods of man meat ranks high—not only because of the percentage of protein contained, but principally because the protein of meat is of high biologic quality—able to satisfy every protein need.

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More in style than ever . . . that's popular Johnnie Walker. For a smoothness and mellowness that's unsurpassed . . . treat yourself to this choice scotch whisky.



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1½ GRAINS—STAYNER 86

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Aminophylline (Stayner) is available in 3 grain as well as 1½ grain tablets for use in the relief of anginal pain. Like all other Stayner products, Aminophylline (Stayner) is manufactured under a meticulous control system.

When you prescribe Stayner products you have full assurance of quality, and your patients benefit by the economies made possible by having our modern well-equipped laboratory conveniently located on the Pacific Coast.

Stayner products are promoted by ethical methods only, and available through prescription pharmacists.

Aminophylline (Stayner 86 and 87) and Aminophylline and Phenobarbital (Stayner 88 and 89) are indicated as aids in the prevention of anginal attacks, in bronchial asthma, paroxysmal dyspnea, Cheyne-Stokes respiration, and the relief of pain due to coronary sclerosis.

AMINOPHYLLINE and PHENOBARBITAL

STAYNER 88

Each tablet contains Aminophylline, 1½ grains, (0.097 Gm) and Phenobarbital, ¼ grain, (0.0162 Gm)

STAYNER 89

East tablet contains Aminophylline, 1½ grains, (0.097 Gm) and Phenobarbital, ½ grain, (0.0325 Gm.)

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• Clinical reports agree that Schieffelin Benzestrol satisfactorily alleviates not only menopausal vasomotor reactions but also other associated climacteric symptoms, such as headaches, joint pains, nervousness and fatigability.

Dose: Oral 2 to 3 mg. daily.

Intramuscular ½ to 1 cc. every 4 to 7 days.

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Dose: 1 or 2 vaginal tablets inserted daily.

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PROMISCUOUS WOMEN ARE MAJOR FACTORS IN VENEREAL SPREAD

(Continued from Page 34)

those suspected of having a venereal disease.

13. Adequate treatment and physical quarantine for those unwilling to submit voluntarily to medical care.

14. Free treatment for those who cannot afford to pay.

15. Active venereal disease case finding and holding adequately supported by public funds.

16. Recognition by public health workers of the strategic leadership to be given by the health department in building a defense against venereal disease.

Treatment of Veterans "Community Problem"

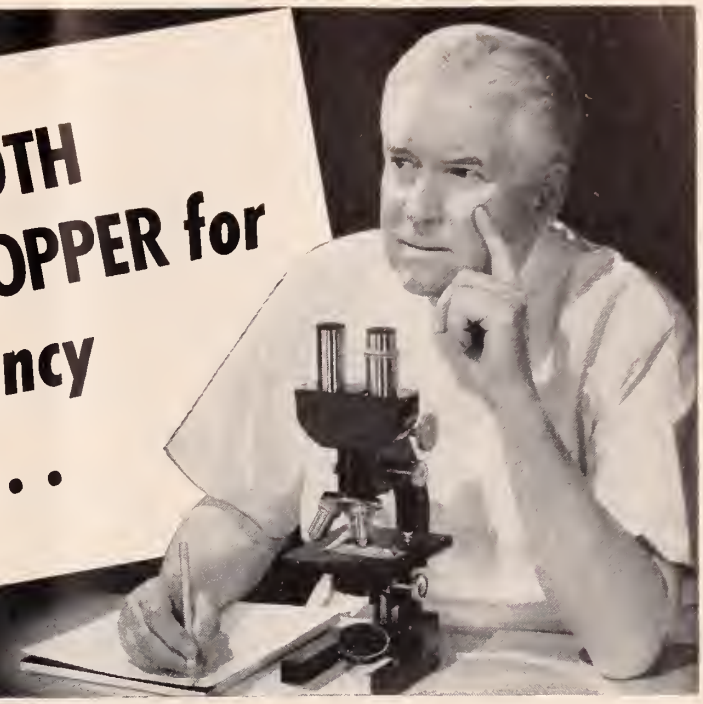
The State of Michigan offers a splendid example of what may be done at the state and local level to help meet one of the most serious problems of the war—the treatment of veterans suffering from nervous or mental maladjustments, or neuro-psychiatrics as they are known technically.

The Michigan program was set up under direction of Col. Philip C. Pack, retired, director of the state's office of veterans' affairs, and has attracted the attention of people interested in adequate treatment for these war veterans.

Emphasizing the size of this problem and the need for action now, Col. Pack says that those who consider it purely a Federal problem and "shrug away responsibility

(Continued on Page 40)

You Need BOTH IRON and COPPER for Iron Deficiency Anemias . . .



WISCONSIN ALUMNI RESEARCH FOUNDATION
APPROVED for COPPER-IRON upon periodic tests

Here's Your Guarantee

This Seal or mention of the Foundation's name on the package is your assurance that licensed Copper-Iron products are approved upon periodic tests.

Utilization of *iron* in hemoglobin regeneration depends upon *copper. Copper* is needed to catalyze the iron for the making of hemoglobin. In Foundation-licensed compounds copper and iron are always combined in proper ratio and amounts. This assures greater certainty of response, faster recovery, higher hemoglobin levels. Dosage is smaller, gastro-intestinal upsets extremely rare and patients' cooperation much improved.

Numerous clinical studies have demonstrated these advantages on hundreds of patients. Why not standardize on Copper-Iron Compounds for your iron-deficiency anemia cases.

If you haven't read the Foundation's two interesting booklets on hemoglobin regeneration . . . write for them today.



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TREATMENT OF VETERANS "COMMUNITY PROBLEMS"

(Continued from Page 38)

on that theory, are blind to the situation and its future social implications." In the end it becomes a community problem.

Acting on this conviction, his office has prepared a state-wide program of out-patient treatment, already partially in operation, providing clinics in eleven Michigan cities—Detroit, Kalamazoo, Grand Rapids, Lansing, Flint, Pontiac, Owosso, Ann Arbor, Saginaw, Traverse City and Newberry.

Out-patient treatment is one of the major necessities, and in this the U. S. veterans administration is admittedly short. It is a tremendous problem, with numerous difficulties, among them the limited facilities now available, and the acute shortage of trained psychiatrists.

Michigan Set-Up

This latter problem is being approached in the Michigan plan by recruiting volunteers from the ranks of psychiatrists. They are giving their services free at the clinics which will be open four hours an evening, six nights a week, in each of the eleven cities. Computing at a low hourly average for such professional service, these psychiatrists are donating $109,200 worth of their time.

Various social agencies, already recruited and organized, will prepare free an average of 800 case histories a month which, if it were paid for, would cost $33,600. In the Michigan set-up there is a state coördinator in the office of veterans' affairs, with 11 clinic secretaries. Coöperating in the program are these agencies

(Continued on Page 42)



Walker vitamins are good vitamins

. . . **Good** for physicians to prescribe because they fill real therapeutic needs with efficiency, and conform to the highest ethical standards of quality. **Good** for patients to take because careful laboratory control assures consistent uniformity of vitamin potencies, and because they are convenient to take. **Good** also, because they offer physician and patient alike, pharmaceutically elegant vitamin preparations at commendably low prices.

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(25 Mg., 50 Mg., 100 Mg.)

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TREATMENT OF VETERANS "COMMUNITY PROBLEM"

(Continued from Page 40)

—Michigan Society of Neurology and Psychiatry, State Hospital Commission, Community Chest, Michigan Society for Mental Hygiene, State Welfare Commission and Department of Vocational Education.

What Michigan is doing could be duplicated by other states. State help is essential in this, to supplant Federal programs. The opportunity presented offers a challenge to the states to justify their recently reasserted claims of responsibility in government. Governor Dewey, in the veterans' rehabilitation program which he submitted recently to the New York State Legislature, provided for a state veterans' psychiatric consulting service.

Repair Involves Everyone

Michigan was forehanded in tackling the psychiatric problem. Col. Pack's office began working on a state program last May. It took some time to set it up, to bring the various coöperating organizations together.

From his observations of servicemen in several theaters of operations, ranging from the Arctic to the tropics, both in this and the first World War, Col. Pack says his conclusion is that the number of veterans requiring mental therapy will be great.

He concluded also that a majority of men requiring mental therapy are in no sense mentally unbalanced, that their fixations will disappear under proper care in a great majority of cases, and that a majority will not require hospitalization.

"But the most definite conclusion I have been able to

(Continued on Page 43)

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TREATMENT OF VETERANS "COMMUNITY PROBLEMS"

(Continued from Page 42)

draw," he said, "is that the problem cannot be avoided by saying 'it's a Federal responsibility.' It is a community responsibility and must be solved on the local level.

"This has been a total war, involving everyone. The repair work, whether to men, machines or morale is a problem involving everyone and it is a problem that must be squarely faced for many years to come. Only the socially blind or indifferent can refuse to face that fact." —Thomas L. Stokes in San Francisco *News*.

Too Much Caffeine Affects Stomach

Evidence that excessive amounts of caffeine, whether taken in coffee, soft drinks or tea, may help to cause stomach ulcers in susceptible persons was presented to the American Medical Association recently.

The work was shown in the annual scientific exhibit by Doctors J. A. Roth, A. C. Ivy and A. J. Atkinson of Northwestern University School of Medicine.

They tried cats first, then humans. On cats they proved that caffeine, which was given by intramuscular injections, caused ulcers in 40 to 50 per cent of the animals. They showed that the caffeine rendered the stomach linings more susceptible to erosion.

No human was used as a guinea pig to get ulcers. But the reaction of normal people and stomach ulcer

(Continued on Page 46)

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Edit.: Ill. Med. J. 82:407 (Dec.) 1942

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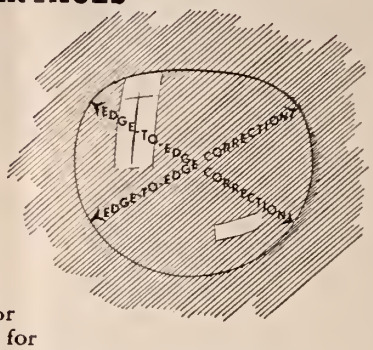
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TOO MUCH CAFFEINE AFFECTS STOMACH

(Continued from Page 43)

patients when given the amount of caffeine in two and a half cups of coffee seemed to confirm the animal findings.

That much caffeine caused usually a big rise in stomach acid. In normal persons this rise was transient. Among those with ulcers the rise was prolonged. It was so prolonged that the physicians said a heavy drink of caffeine may help to diagnose suspected ulcers.

Among 50 normal persons tested there were five who showed acid reactions resembling those of ulcer patients. Four of the five later developed stomach troubles and one got an early type ulcer.

The five were described as "conscientious, outwardly composed, inwardly tense" persons.

Caffeine and alcohol together raised the acid response of human stomachs 65 per cent higher than the sum of the responses to each drug separately.

Alcohol differed, however, from caffeine in that the rise in acid production of the stomach was the same in both normal and gastric ulcer persons.

Cream and sugar in coffee cut down the acid effect by half on normal persons and by about 40 per cent on ulcer patients.

One cup of coffee, the Northwestern measurements showed, contains 100 milligrams of caffeine; one cup of tea, 17 to 33 milligrams; a bottle of one soft drink, 77 milligrams, and a bottle of another brand, 33. All of these figures are much under the amount of caffeine used in the tests on humans.

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Penicillin DOSAGE TABLE*

INDICATIONS	INITIAL DOSE (UNITS)	CONTINUING DOSAGE (UNITS)	UNITS IN 24 HR.	REMARKS
Serious Infections (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus) Adults and children	15,000 to 20,000	(a) Intravenous drip: 2000 to 5000 every hr.	40,000 to 120,000 or more	(a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.
		or (b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.	40,000 to 120,000 or more	(b) Concentration: 5000 U. per cc. normal saline.
		or (c) Intramuscular drip	40,000 to 120,000 or more	(c) Total daily dose in 250 cc. normal saline.
Infants	5000 to 10,000	3000 to 10,000 intramuscularly every 3 hr.	20,000 to 40,000 or more	Each dose in 1 or 2 cc. of normal saline.
Chronically infected compound injuries, osteomyelitis, etc. Adults and children	5000 to 10,000	10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times.	40,000 to 120,000 or more	Concentration for intramuscular inj.: 5000 U. per cc. normal saline. For intravenous inj.: 1000 to 5000 U. per cc. Supplement with local treatment.
Gonorrhea	20,000 every 3 hr. intramuscularly for 5 doses		100,000	Results of treatment should be controlled by culture of exudate.
Empyema Adults and children	30,000 to 40,000 once or twice daily into empyema cavity		30,000 to 80,000	Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.
Meningitis Adults and children	10,000 once or twice daily into subarachnoid space or intracisternally		10,000 to 20,000	Concentration: 1000 U. per cc. normal saline.
Bacterial Endocarditis Adults and children	25,000 to 40,000	25,000 to 40,000 every 3 hr. intramuscularly	200,000 to 300,000	Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.

*Based upon recommendations by Chester S. Keefer, *War Production Board Penicillin Leaflet*, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

Write for pocket size copies of this Dosage Table

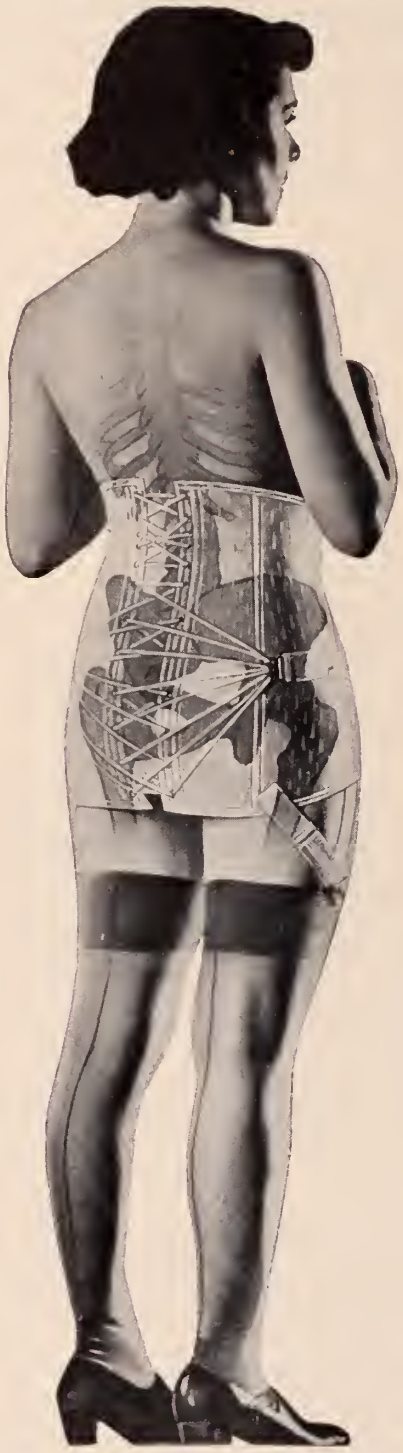
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1. Bull. N. Y. Acad. Med. 18:497 (Aug.) 1942.

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.

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*Welch, Henry, and Hunter, Albert C., Method for Determining the Effect of Chemical Antisepsis on Phagocytosis, Am. Jnl. of Public Health, Vol. 30, No. 2, Feb. 1940.

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Colonel Menninger Receives Lasker Award

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The citation states that under Colonel Menninger's direction "preventive psychiatry has been enhanced by a series of lectures on personal adjustment for all officers and enlisted men" and that "through his efforts the emphasis on diagnosis and disposition has been shifted to active treatment, retraining and reconditioning for resumption of military duty or return to civilian life." The citation further states that "Colonel Menninger has taken very much to heart the difficulties that confront the soldier discharged for neuropsychiatric disability. He has taken every opportunity and mean to correct the popular misunderstanding of these diagnoses."

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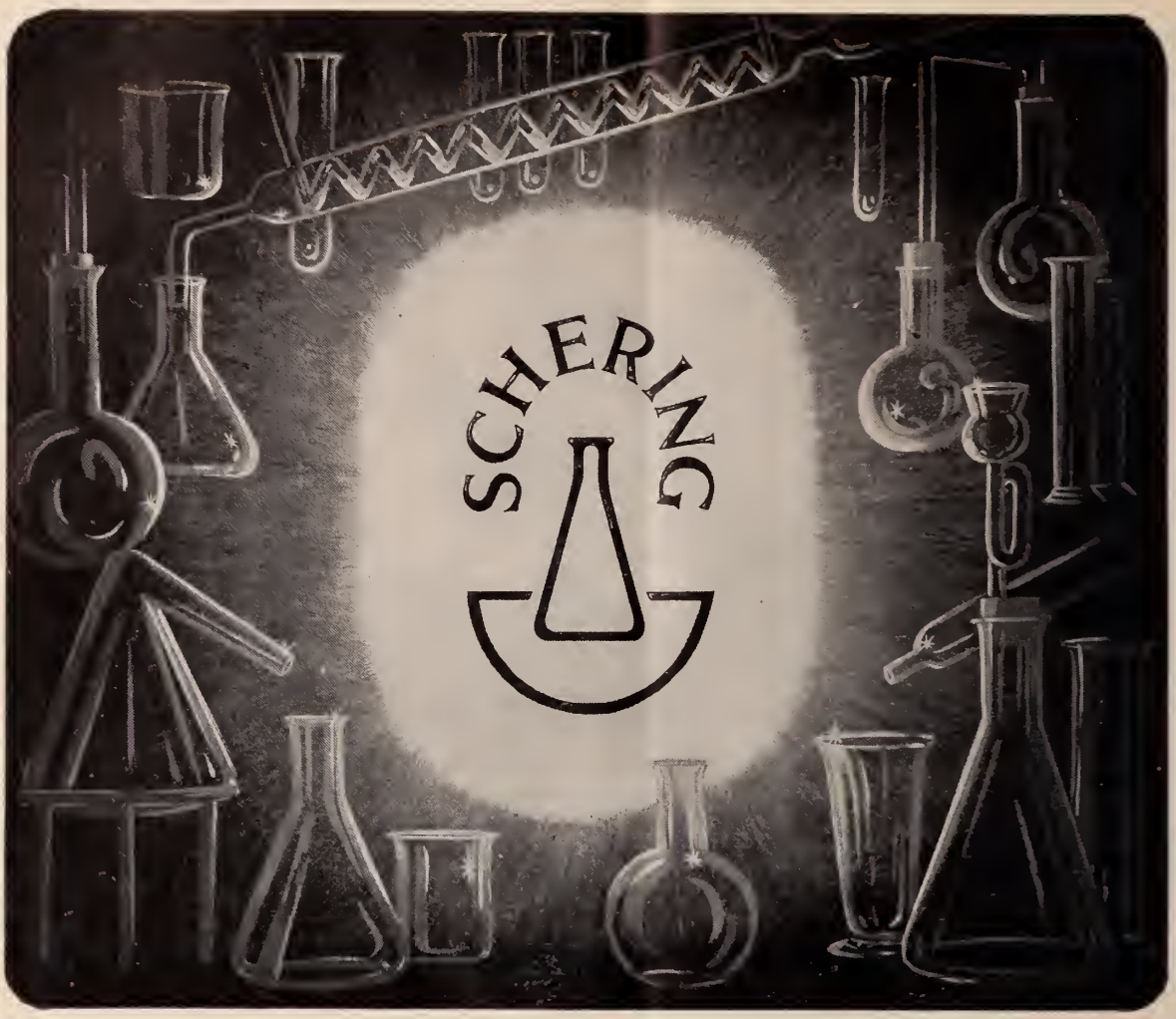
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1. Compton, B. C.; Bieren, R. E.; Jones, E. G.; Inloes Jr, B. H.; Kordash, T., and Hundley, J. M.: Treatment of Gonococcic Vulvovaginitis, *J.A.M.A.* 127:6 (Jan. 6) 1945.

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(Continued from Page 3)

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

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Fundamentals of Pharmacology. By Clinton H. Thienes, M.D., Ph.D., Professor and Head of the Department of Pharmacology, School of Medicine, University of Southern California, Attending Pathologist (Toxicology), Los Angeles County Hospital. Medical Students Series. Paul B. Hoeber, Inc. Cloth. Price, $5.75. Pp. 497. New York and London: Harper & Brothers, 1945.

The Male Hormone. By Paul de Kruif. Cloth. Price, $2.50. Pp. 243. New York: Harcourt, Brace and Company, 1945.

BOOK REVIEWS

The Examination of Reflexes. A Simplification. By Robert Wartenberg, M.D. Foreword by Foster Kennedy, M.D. Cloth. Price, $2.50. Pp. 222. Chicago: The Year Book Publishers, Inc., 1945.

A monograph of over two hundred pages indexed as to authors and subjects and with a comprehensive bibliography. This is a monumental and needed work compiled by an expert and highly experienced clinician. His comments and the appraisal of the various reflexes are of a special value. How many times are we, probably unduly, embarrassed by some reference to an unfamiliar reflex. The answers can be found here. The work should be in the hands of all who make neurological examinations, and available as reference work for all students.

HOWARD C. NAFFZIGER, M. D.

(Continued on Page 10)

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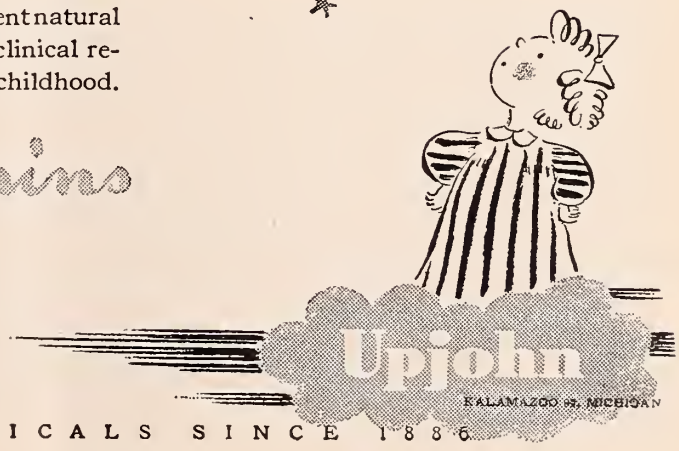
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1. Am. J. Dis. Child. **54**: 1227, 1937.



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BOOK REVIEWS

(Continued from Page 7)

Urological Surgery. By Austin Ingram Dodson, M.D., F.A.C.S., Richmond, Virginia, Professor of Urology, Medical College of Virginia; Urologist to the Hospital Division, Medical College of Virginia; Urologist to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. With contributions by R. A. Berger, M.D., F.A.C.R.; Douglas G. Chapman, M.D., F.A.C.P.; Everett Idris Evans, Ph.D., M.D.; Fred M. Hodges, M.D., F.A.C.R.; Major Guy Winston Horsley; Linwood D. Keyser, M.D., F.A.C.S.; and Lawrence O. Sneed, M.D., F.A.C.R. Cloth. Price, $10.00. Pp. 768, with 576 illustrations. St. Louis: The C. V. Mosby Company, 1944.

In a book on urological surgery the average urologist will want to find the answer to all of his questions and a discussion of his operative problems: a book which covers the field completely, giving the history and development of all major procedures, an outline at least of most of those modifications in use and the technique in detail of the best of these with a critical discussion of their respective advantages and disadvantages. When pertinent, he will want to know the sort of preparation the patient will need for the particular operation and the special care to be given him afterwards. To be authoritative the writer of such a book will have learned the hard way by actual operative experience. While Dodson's book is not complete in the above sense, does not tell who did the first nephrectomy nor when, where and for what, does not report the development of the major procedures as for example perineal prostatectomy (Proust, Young, Geraghty, Gibson, Belt), suprapubic prostatectomy (Fuller, Freyer, Squires, Thompson-Walker, Harris), and transurethral prostatectomy (Young, Stern,

(Continued on Page 14)

Penicillin DOSAGE TABLE*

INDICATIONS	INITIAL DOSE (UNITS)	CONTINUING DOSAGE (UNITS)	UNITS IN 24 HR.	REMARKS
Serious Infections (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus) Adults and children	15,000 to 20,000	(a) Intravenous drip: 2000 to 5000 every hr.	40,000 to 120,000 or more	(a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.
		or (b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.	40,000 to 120,000 or more	(b) Concentration: 5000 U. per cc. normal saline.
		or (c) Intramuscular drip	40,000 to 120,000 or more	(c) Total daily dose in 250 cc. normal saline.
Infants	5000 to 10,000	3000 to 10,000 intramuscularly every 3 hr.	20,000 to 40,000 or more	Each dose in 1 or 2 cc. of normal saline.
Chronically infected compound injuries, osteomyelitis, etc. Adults and children	5000 to 10,000	10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times.	40,000 to 120,000 or more	Concentration for intramuscular inj.: 5000 U. per cc. normal saline. For intravenous inj.: 1000 to 5000 U. per cc. Supplement with local treatment.
Gonorrhea	20,000 every 3 hr. intramuscularly for 5 doses		100,000	Results of treatment should be controlled by culture of exudate.
Empyema Adults and children	30,000 to 40,000 once or twice daily into empyema cavity		30,000 to 80,000	Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.
Meningitis Adults and children	10,000 once or twice daily into subarachnoid space or intracisternally		10,000 to 20,000	Concentration: 1000 U. per cc. normal saline.
Bacterial Endocarditis Adults and children	25,000 to 40,000	25,000 to 40,000 every 3 hr. intramuscularly	200,000 to 300,000	Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.

*Based upon recommendations by Chester S. Keefer, *War Production Board Penicillin Leaflet*, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

Write for pocket size copies of this Dosage Table

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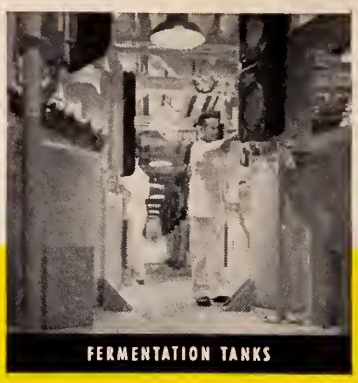
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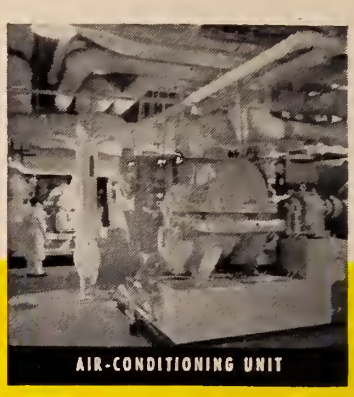
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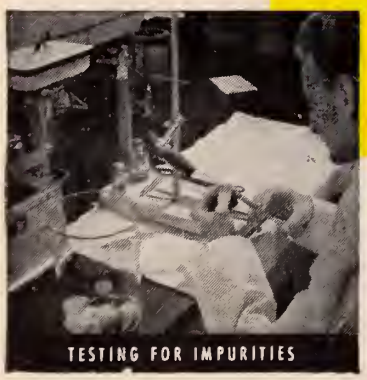
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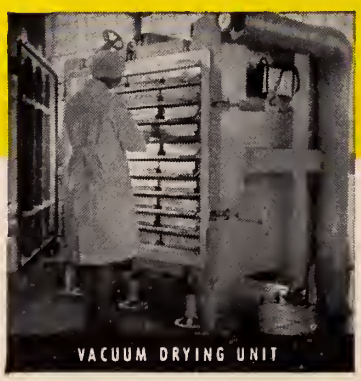
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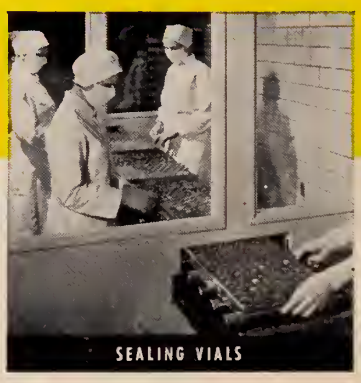
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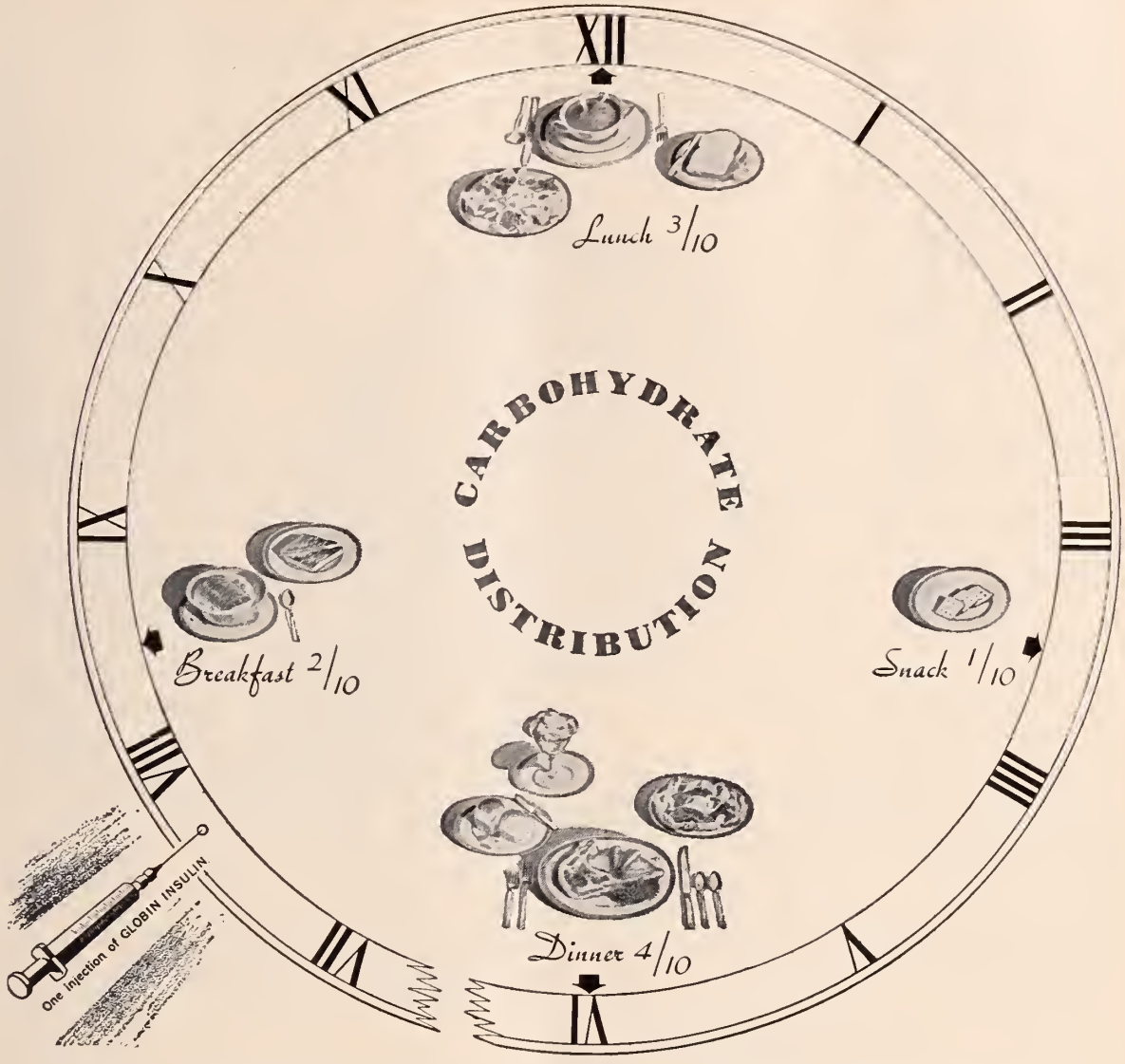
BOOK REVIEWS

(Continued from Page 10)

Davis, McCarthy, Braasch, Bumpus, Alcock, Nesbit); does not outline all of the various modifications (except possibly nephropexy) and does not discuss their relative merits fully,[1] it is nevertheless well written and quite obviously by an expert surgeon who knows what he knows from experience. This last gives real quality to the book and after all is what the writer states in his preface as his main purpose, "an aid in clinical work and as a surgical supplement to the excellent books on principles and practice of Urology now in use." The value of the first six chapters (I Anatomy, II Diagnosis, III Excretory Urography, IV Radiation Therapy, V Acid Base Balance and Fluid Administration, VI Blood Transfusion), therefore, is debatable, the meat in them is lean and could have been interspersed briefly elsewhere, and then these 136 pages would have permitted the inclusion of "many excellent operative procedures . . . necessarily left out for lack of space." Either prejudice or practice might explain the 23 pages given up to nephroptosis but less than two to the surgery of cancer of the prostate. Failure to describe the position of the patient for the major operations is regrettable since it is essential for adequate exposure in most of them. The most useful incision for extraperitoneal exposure of the kidney is omitted; an incision one centimeter below and parallel to the 12th rib with division of the costovertebral ligament giving as good or better exposure than with resection of the rib. The best exposure of the bladder and lower ureter (Charney) is not mentioned.

References are a little obsolete, very few after 1940 and the earlier contributions have not always been checked for changes as for instance "the method of

(Continued on Page 20)



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BOOK REVIEWS

(Continued from Page 14)

retroprostatoseminal vesiculocystectomy" (page 516), described in 1935 was entirely discarded in 1939 for a combined suprapubic-perineal total cystectomy. The subject of ureterosigmoidostomy is not up to date, leaving out the preparation of the patient for it (particularly with succinyl sulfathiazole) and the many newer methods which have been published since Coffey.

By and large the book is full of practical suggestions. It is stimulating literature for everyone doing urological surgery and being the first book of its kind should be in the library of and read by each one of them.

Frank Hinman.

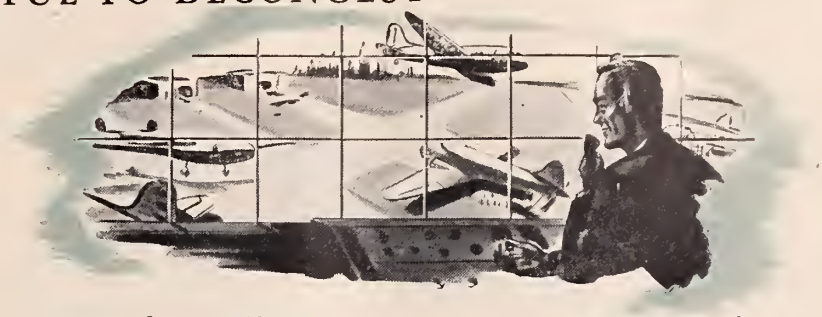
TWENTY-FIVE YEARS AGO

(Continued from Text Page 370)

Doctors to Defeat "Quack" Solons.—Under this appropriate headline the San Francisco *Examiner* for May 19, 1920, says as follows: "Come all ye little legislators and listen unto me! The doctor man will get you if you don't watch out. The doctors of California are organized into the strongest medical association in this country—a model organization that other states are beginning to imitate. The big pill doctors and the little pill doctors have joined hands. More than 3,000 of them are in the 'League for the Conservation of Public Health.' All the leading men of the regular healing profession are in it. The League publishes a magazine called '*Better Health.*' In its most recent issue 'Better Health' says: 'Watch the next legislature.' . . ."

(Continued on Page 24)

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The quotation which heads this page provides, out of the author's own experience, striking testimony to the dramatic value of Benzedrine Sulfate in the relief of simple depression, with its associated symptoms of anhedonia, chronic fatigue and retardation.

*Reiter, P. J., Experience with Benzedrine, Ugeskr. f. laeger, 99:459-460, 1937.

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TWENTY-FIVE YEARS AGO

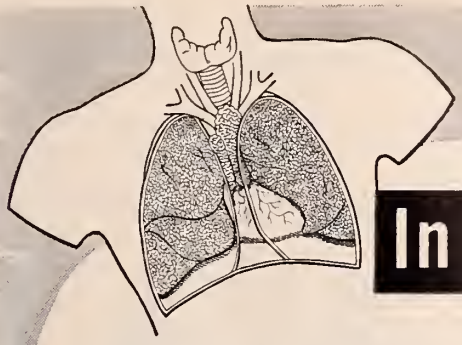
(Continued from Page 20)

The Rôle of the Physician in Industrial Medicine.—Volumes could be, and are, written on the rôle of the medical profession in modern industry. The average doctor can be reminded with advantage from time to time of some of these fundamental relationships. Employers need the physician because they are coming to recognize that employees must be kept well, that preventable hazards must be abolished, that the employee must be shielded from necessary hazards, that the disabled employee must be returned to work skillfully and quickly, and that the large group of physically abnormal employees must be given work adapted to their capabilities. All of this is the function of industrial medicine. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article "Concerning Osteopathy," by Emmet Rixford, M.D., San Francisco.—It is a sad commentary on the degree of education and understanding of the general public that its attitude toward the things which the student of public health knows most vitally concern the human race, its development, its health, its efficiency, its very perpetuation, is that of neglect, of "laissez faire." The world is too busy to bother about that which is not obvious. "Let the doctors worry about it; they are the ones interested!" Really this is worse than the attitude of the ostrich for, by burying his head in the sand, he shows at least that he is alive to the approach of danger. But it is said people are discussing health matters now as never before. Shall we look upon the ever increasing

(Continued on Page 28)



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DURING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).* Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

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*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

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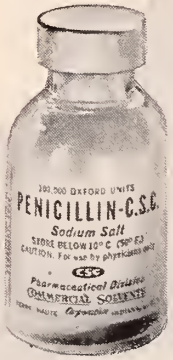
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*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

crop of "antis" as evidence of an awakening public consciousness in matters of public health and clean living?

From an Article on "The X-Ray as an Aid in Diagnosis of Non-Tubercular Pulmonary Conditions," by Lloyd Bryan, M.D., San Francisco.—As the subject of x-ray diagnosis of non-tuberculous pulmonary conditions is a very extensive one, it seems wisest to limit the discussion almost entirely to a demonstration of lantern slides showing only those conditions which in our experience we have found to be the ones most commonly diagnosed tuberculosis and to give the important points in the differential diagnosis. . . .

From an Article on "Malingering: Its Relation to the Doctor," by Joseph Catton, M.D., San Francisco.—This communication deals with malingering, especially with its relation to the doctor. Lying, deceit, feigning or any type of fraud, when applied to matters of disease or disability, constitute malingering. The fraud may relate itself to the existence, etiology, symptomatology or severity of a disease or disability.

Malingering in one or another of its forms may be met within public hospitals, asylums, jails, and in the military, and in connection with industrial accident and health insurance. It may be resorted to by persons bringing suit for personal bodily injury or by those on trial for murder. . . .

Note—The following minimum Fee Schedule was adopted by the Society at the Santa Barbara meeting on May 11th, 1920. It has been accepted by the Industrial Accident Commission and by the Insurance Carriers. It represents a general increase of over 27 per cent and is in effect June 1, 1920. . . .

Excerpt from Miscellaneous: Los Angeles Tuberculosis Association.—At the annual meeting of the Los Angeles Tuberculosis Association, February 8, a reorganization was effected and the following officers elected:

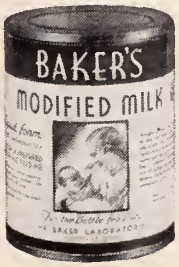
Mrs. J. J. A. Van Kaathoven, president; Dr. Charles C. Browning, vice-president; Louis M. Cole, vice-president; George H. Kress, vice-president; Mrs. Benjamin

(Continued on Page 30)



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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

Goldman, secretary; John P. Burke, treasurer; Mrs. J. M. Danziger, chairman of finance; Dr. W. Jarvis Barlow, chairman of advisory council; Dr. Norman Bridge, president emeritus. . . .

From an Article on "Gleanings From a Year of Country Practice," by William B. Smith, M.D., Kernville, Calif.—That there may be no doubt that the title is correct, let me say that my territory covers a stretch of mountain country and valleys, sixty miles east to the desert, forty miles south to the railroad, thirty miles west to the edge of the San Joaquin foothills, and thirty miles north into the high Sierras. In all this area there is a census population of over one thousand souls, ranchers, miners, trappers, and Power Company employees. The health of the community is rather oppressive to an ambitious young medico, but to tide over the slack times, many of my families pay two dollars per month "dead or alive," and get the benefit of a 25 cent mileage rate instead of the $1.00 rate paid by those of less foresight. And let me say that my experience teaches me that any man starting without financial or professional backing will save years of debt, discouragement, and health-destroying worry, if he will be content to look for just such a country location where he will find need of his services, instant appreciation, and a sure living for himself and family.

And let the highlights of my past year go to show that he will not have wasted his time nor his training either. So listen to my gleanings:

Dec., 1918, to Jan. 15, 1919. Influenza epidemic of 85

(Continued on Page 36)



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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 62 JUNE, 1945 NO. 6

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker (Chairman) Fresno 1946
F. Burton Jones Vallejo 1947
R. H. Sundberg San Diego 1948
Secretary-Editor ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

VI. PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Continued)

Why the Comments and Items on Proposed Compulsory Sickness Insurance Laws Have Been Continued.—The leading editorial of each issue of CALIFORNIA AND WESTERN MEDICINE, for the last six months, has received the above caption, since the subject is one of immediate and paramount interest, both to physicians and the public of California. Previous comments have endeavored to present a skeleton outline concerning the month to month status of proposed sickness insurance laws now pending in the current 56th California Legislature, through which the proponents were hoping to bring into operation a system of compulsory medical and hospitalization service.

In addition to the above discussions, a considerable amount of space has been allocated to press items in which the views of proponents and opponents of the statutes submitted were portrayed. This policy is continued in the current issue since, in controversial issues, it is important not only to evaluate one's own opinions regarding modes of action, but also to appreciate and consider the arguments and contentions put forth by opposition groups.

If the arguments of the opposition have merit, that fact should be recognized and accepted, and one's own course of action, modified. If, however, no such merit or advantages are found in the statements of the opposing forces, it should make us only the more determined in efforts to attain our own objectives.

* * *

Future Sickness Legislation.—With the large amount of thought now being given to the problem of securing adequate medical care for all classes of citizens, we must realize it is only a matter of time when remedial procedures designed to overcome deficiencies which may now exist in the distribution of medical care, will be brought into being.

On the other hand, illness among lower income groups of citizens, especially when combined with financial and other deficiencies of modern-day living, can easily lead to the exploitation by theorists and well meaning groups or individuals, of supposed remedial legislation that has its basis in transient emotionalism, rather than upon sound actuarial or healing art experience. Also, it is understandable that those who have undergone the

many hardships of serious illness and its medical care and hospitalization expense are usually willing to accept such proferred State aid.

The bare statement that the subject of adequate "medical care has been studied for thirty years," and therefore, the time to act is *now*, does not in itself warrant the enactment of laws that would make existing deficiencies worse instead of better. The question at issue is not, on whether a subject may have been studied, but rather, has a satisfactory and practical solution of the problem been found? To date, on that point, the answer is, "'No"!

Some of the staunchest California proponents of certain pending sickness and hospital insurance and coverage legislation seem unable to understand the great gap that may exist between the recognition of a problem, and its proper solution.

* * *

Governor Warren's Defeat of June 4.—Referring to pending California legislation, it is gratifying to be able to write that the sickness insurance reformers have not been successful in the present 56th California Legislature. At the time of this writing, the news has come over the wires, that Governor Warren's revised "hospitalization" bill (A.B. 2201) has gone down to defeat, by a vote of 45 to 32 in the Assembly, when appeal was made by its sponsors to take the bill from the Committee on Public Health and bring the measure to the floor of the Assembly for consideration by the Lower House. The bill remains locked in the files of the Committee on Public Health. It is hoped that such will continue to be its status until the Legislature adjourns, the tentative, reported date for which,—June 16th,—is not far distant.

Members of the Association who wish to learn more of legislative happenings on the sickness insurance bills—and every California physician should be interested—will find informative items on pages 350-360, where they have been inserted both for legislative reference and historical C.M.A. record. (Note.—Legal adjournment did take place on June 16.)

* * *

Misleading Nature of Governor Warren's A.B. 2201.—An analysis of A.B. 2201—Governor Warren's "hospitalization modification" of his own A.B. 800 and C.I.O. (A.B. 449) bills, appears in this issue on page 355.

The *comment* thereon should be read, since the title of the bill as it has appeared in the press, does not tell the real story of the provisions contained in the proposed law. (See page 357.)

That hospital expenses in serious illness may bring great financial hardships to families and individuals is understood by almost every citizen. However, when a statute containing provisions that would prevent proper development of hospitals, or promotion of more and better medical care is submitted to our Legislature, as a "must pass" measure, the medical profession would be false to its obligations to the public, and to its own traditions, if it did not make every legitimate effort to prevent the enactment of such legislation.

Fortunately, in spite of the political forces and combinations that were brought into action by the State administration, A.B. 2201 on June 4th met with the same fate as A.B. 800 (Warren), and A.B. 449 (C.I.O.), but with even greater rebuff.

* * *

Possible Modes of Legislative and Electorate Action.—Six months ago when this present series of comments began, reference was made in the January issue of California and Western Medicine, that the 56th California Legislature, in regard to compulsory sickness insurance bills, had power and choice of action, as follows:

(a) The Legislature could enact a compulsory sickness insurance bill, sending the same to the Governor for approval and enactment;

(b) The Legislature could draft a bill and submit it to the electorate, for referendum vote and approval;

(c) The Legislature could choose to do neither of the above, but appoint an Interim Committee to study the subject, with report or recommendations to the 57th Legislature which will convene in January, 1947;

(d) The C.I.O. alone, or with other groups, could make an effort to secure the required number of signatures of voters, necessary to place such a compulsory sickness law on the ballot of either a special election to be called by Governor Warren, or on the state election ballot of November, 1946.

The above are the possibilities in procedure. What the present 56th California Legislature will finally do, will be known when it adjourns, some time in the month of June.

(Later Note.—An Interim Committee was appointed.)

* * *

Present Victory is Only a Breathing Spell—the Battle Must be Carried On.—In the meantime, the following may be stated to the members of the California Medical Association:

This year's battle at Sacramento has been one of the hardest the California Medical Association has ever been called upon to face.

Thanks are given to the many workers, both within and without the profession, who have lent a hand in efforts to prevent the enactment of the immature and dangerous compulsory sickness insurance laws that have been proposed.

The battle, however, is not over. We have only a breathing spell, during which the members of the medical profession can again take stock, and decide on future courses of action.

The active interest and support of all physicians in the continued study of the issues at stake, is urged.

WAGNER-MURRAY "SOCIAL SECURITY AMENDMENT OF 1945"—(S. 1050). COMPANION BILL IS DINGELL (H.R. 3293).

An Interesting Letter from Senator Wagner of New York.—For the information of members of the California Medical Association a

letter from Senator Robert F. Wagner of New York, dated May 31, and addressed to the Editor of California and Western Medicine, follows:

(copy)

Robert F. Wagner, New York

United States Senate

Washington, D. C.

May 31, 1945.

George H. Kress, M.D.,
Editor, California and Western Medicine,
San Francisco, California.

Dear Dr. Kress:

On Thursday, May 24, 1945, I introduced with Senator Murray a bill, S. 1050, entitled: "The Social Security Amendments of 1945." The bill provides for "the national security, health and public welfare." Representative Dingell of Michigan introduced a companion bill (H.R. 3293) in the House at the same time.

I am forwarding the bill itself, and a copy of my speech in the Senate for your information and use.

I particularly invite your earnest study of the provisions of the bill relating to health. There is absolutely no intention on the part of the authors to "socialize" medicine, nor does the bill do so. We are opposed to socialized medicine or to State medicine. The health insurance provisions of the bill are intended simply to provide a method of paying medical costs in advance and in small convenient amounts.

During the formulation of this bill, we have benefited greatly from the constructive advice and suggestions of practicing physicians, and of physicians in clinical and teaching positions. Their constructive suggestions have resulted in changes in the bill which we presented in the last Congress. Undoubtedly other changes will be made before this bill is enacted into law. We wish to have it known that we invite constructive suggestions from the medical profession.

In addition, members of the medical profession will be given full opportunity to voice their opinions in open hearings when the bill is considered in Committee.

I hope that you will print this letter in your Journal and that you will join me in urging the medical profession to undertake an earnest study of the actual provisions of the bill. In this way you can help immeasurably in avoiding misunderstanding and misinterpretation of the legislation and in stimulating physicians and medical and hospital organizations to come forward with constructive suggestions and advice.

Sincerely yours,

(Signed) Robert F. Wagner.

* * *

Senator Wagner Asserts He Believes in the "American System of Free Enterprise."—In Senator Wagner's letter, the second paragraph states:

I am forwarding the bill itself, and a copy of my speech in the Senate, for your information and use.

And on the first page of the mimeographed copy of the speech, the fourth paragraph opens with the remarkable assertion:

I believe in the American system of free enterprise. [!!!]

Those who have studied the text of the former Wagner-Murray bill will find it difficult to reconcile Senator Wagner's above statement with what are practically *compulsory* inclusions concerning health (sickness) coverage, as outlined in the present Wagner-Murray bill (S. 1050), or its companion House of Representatives measure (H.R. 3293), introduced by Congressman Dingell.

* * *

The New Wagner Bill (S. 1050) Is a Lengthy Document.—S. 1050 as presented to the 79th U. S. Congress on May 24, needs some 185 pages. Section 9 is captioned: "Title II—National Social Insurance System." Part A, dealing with "Prepaid Personal Health Service Insurance," commences on page 71 and carries through to page 106.

In the current issue of California and Western Medicine, additional press comments appear concerning the present Wagner-Murray-Dingell bill, which its sponsors state is an "Act [that] may be cited as the Social Security Amendments of 1945." (See page 359 for a digest.)

In the June 2, 1945, number of the *Journal of the American Medical Association,* on pages 364-365, editorial comment is given; and on pages 369-372 an analysis by the A.M.A. Bureau of Legal Medicine is outlined. Physicians who are interested should take the time to scan the articles.

* * *

Senator Wagner's Outline of the Major Health Objectives of His Bill.—In spite of the fact that Senators Wagner and Murray and Congressman Dingell have deemed it proper to have had practically no official consultation with the constituted authorities of the American Medical Association—an organization made up of more than 120,000 Doctors of Medicine who are members of component county medical societies of constituent state associations, space is here taken to present his own explanation of the scope of the "Health Provisions" of his S. 1050:

(copy)

Health Provisions

The legislation which I have introduced includes six provisions which will make available basic health services to all of the people wherever located and whatever their income.

First, there is a program of Federal grants-in-aid and loans to the States for the construction of needed hospitals. It should therefore be possible, over a period of years, to assure that essential and modern hospital and related services are available in all parts of the country, especially the rural areas which are so sadly in need of these services. The most urgently needed hospitals should be built first.

Second, the present Federal grants-in-aid to the States for public health services are broadened and increased, to speed up the progress of preventive and community-wide health services.

Third, the community-wide maternal and child health and welfare services, aided by Federal grants-in-aid to the States, are similarly broadened and strengthened.

Fourth, health insurance is made available to 135,000,000 persons.

All four of the measures which I have just mentioned will greatly help to round out the health services of the Nation. By preventing sickness, disability and premature death, they will pay vast dividends in human welfare and at the same time, reduce the costs of other parts of the social security program. However, unless we provide a method for spreading the cost of medical and hospital

care through social insurance, people will still not obtain the treatment they need.

Fifth, funds are set aside from the social insurance contributions to aid in the rehabilitation of persons who are disabled.

Sixth, grants-in-aid are provided from social insurance funds to nonprofit institutions engaging in research or in professional education.

The financial barrier to adequate hospital and medical care is the basic reason for the unequal distribution of doctors and hospitals as between urban and rural areas, and as between prosperous and underprivileged communities. It is the basic reason for the failure of low-income families to receive as much medical care as the well-to-do, although they have more sickness. It is an important cause of the shockingly high rate of rejections under Selective Service.

Health Insurance

A health insurance system will go a long way toward breaking down this financial barrier. Such a system will enable the people to obtain all needed medical care through small, regular pre-payments based on their earnings, and will give them security against catastrophic costs for which they cannot budget individually. It will encourage doctors to settle in rural areas and communities to construct needed hospitals, health centers, and diagnostic facilities, by assuring adequate incomes, equipment and facilities for modern medical practice. It will benefit patients, doctors and hospitals. . . .

Readers who have taken the time to peruse the above statement concerning Senator Wagner's aspirations may not wish to quarrel with him concerning some of the indicated objectives. The difference of opinion by medical men relates rather to the ways and means Senator Wagner and his advisers have devised to bring about a betterment in certain deficiencies that may exist regarding the adequacy of medical care. Let it be remembered concerning such deficiencies, the people and the State are probably more to blame than the medical profession.

* * *

Senator Wagner's "Opinion" Is Not in Harmony With Facts or Experience.—The paragraph in Senator Wagner's speech that immediately follows the excerpt given above makes one ponder on whether the Honorable Senator always carries through with clear thinking and conclusions. Thus, he states:

Propagandists against health insurance shout "regimentation" of doctors and patients, "lowered standards," "political" and "socialized" medicine, and so on. But health insurance is *not* socialized medicine; it is *not* State medicine. Health insurance is simply a method of paying medical costs in advance and in average amounts. It is simply a method of assuring a person ready access to the medical care that he or she needs by eliminating the financial barrier between the patient and the doctor or the hospital. Therefore, it should be obvious that health insurance does not involve regimentation of doctors or patients. Neither do I believe that the doctors of this country will lower the standards of medical care simply because they are guaranteed payment for their services.

* * *

"Health Insurance"—"Sickness Insurance"—"Poverty Insurance."—In the quotation above given, Senator Wagner starts out with references to "health insurance," or what could be more properly called "sickness insurance"; or, "indirect poverty insurance,"—for when the State furnishes the funds to cover the major cost of catastrophic or other illness, such action in one sense, is "poverty insurance."

* * *

On Whether the Quality of Medical Care May be Lowered.—His final sentence in the quotation just given, states

Neither do I believe that the doctors of this country will lower the standards of medical care simply because they are guaranteed payment for their services.

The Senator's statement to that effect may be a thought that is consoling to his ego or egotism but, after all is said, it is nothing more than an expression of an opinion, rather than a logical conclusion based on sound premises.

The opposite opinion, held by thousands of Doctors of Medicine, founded both on practical experience and their far more intimate knowledge of medical practice, would be a much safer guide for Senators Wagner and Murray and Congressman Dingell to follow. Unfortunately, the three Congressional social welfare reformers seem so obsessed with the brain child they and their advisers have created, that they seem unable to appreciate the glaring deficiencies in their own "cradle to the grave" protective plan. Their reluctance or obstinacy in not being willing to seek information from foundation sources, as represented by the constituted representatives of organized medicine in the United States, is the more amazing since, as practical and successful politicians, they themselves must have noted in how many activities, the injection of political control, direct or indirect, has played havoc with civilian work that had been previously conducted in efficient manner.

* * *

Legislative Course of the Wagner-Murray-Dingell Bill Should be Followed by All Physicians: County Societies Should Discuss It.—Readers are urged to keep themselves in touch with the legislative course of the Wagner-Murray-Dingell bills (S. 1050 and H.R. 3293). The secretary of every county medical society should send a letter to his local Congressman, requesting a copy of S. 1050 and of Senator Wagner's statement of May 24th*. This could then be handed to a volunteer or other committee for presentation of a report at a county society meeting, with perhaps a round table discussion on the merits and demerits of Senator Wagner's plan.

The two Senators and Congressmen from California should be informed concerning the conclusions reached by county medical societies. By proceeding along such or similar lines, a double service will be performed:

(1) The members of the County Medical Societies will be more apt to maintain an interest in this proposed legislation; and

(2) The Congressional representatives from California will be informed concerning the opin-

* Copies of S. 1050 may be secured also, from: Council on Medical Service, American Medical Association, 1835 I St., N. W., Washington 6, D. C.

ions held by a powerful group of their constituents.

The proponents of the Wagner-Murray-Dingell bills are making strenuous efforts to promote their propaganda and legislative campaigns. It is important that members of the medical profession be equally alert, in order that the best interests of the public health may be conserved. Officers and Program Committees of county medical societies have here a definite responsibility.

OFFICIAL MINUTES OF C.M.A. HOUSE OF DELEGATES—NEWLY ELECTED OFFICERS OF SCIENTIFIC SECTIONS

Minutes of Meetings of House of Delegates.—This issue of the OFFICIAL JOURNAL carries the minutes of the meetings of the C.M.A. House of Delegates, held in Los Angeles on May 6-7, 1945. Reference is made thereto because members should at least run their eyes over the records of the proceedings of the constituted highest authority of the California Medical Association. This is the more important since, in order to comply with the directives of the Office of Defense Transportation, many of the component county societies refrained from sending full delegations to this year's annual session.

* * *

Newly Elected Officers of Scientific Sections.—In the current issue, on advertising page 4 appears the complete roster of newly elected officers of the scientific sections of the California Medical Association: Anesthesiology; Dermatology and Syphilology; Eye, Ear, Nose and Throat; General Medicine; General Surgery; Industrial Medicine and Surgery; Neuropsychiatry; Obstetrics and Gynecology; Pathology and Bacteriology; Pediatrics; Public Health; Radiology; and Urology.

Attention is called thereto, because members of the Association who may wish to present papers at the annual session to be held in 1946 in Los Angeles, should write at an early day to the secretary of the Section to be addressed. Such cooperation will be much appreciated by Section Officers, who will welcome also, suggestions on topics for conjoint meetings, panel discussions, symposia or special papers.

McBurney's Point.—Although the sign for operative intervention in appendicitis described by Charles McBurney was subjected to much controversial opinion, the expression "tenderness over McBurney's point" remains in common use. On this description, contained in the article entitled "Discussion on Appendicitis; Indications for Early Laparotomy," rests McBurney's claim to medical fame. It is generally acknowledged that McBurney was an outstanding and able surgeon of his time. —Warner's *Calendar of Medical History.*

This glorious Union shall not perish! Precious legacy of our fathers, it shall go down honored and cherished to our children. Generations unborn shall enjoy its privileges as we have done; and if we leave them poor in all besides, we will transmit to them the boundless wealth of its blessings!

—Edward Everett, *Speech,* at Union Meeting in Faneuil Hall, Boston.

EDITORIAL COMMENT†

ASCORBIC ACID VS. THE COMMON COLD

As part of a detailed study of the epidemiology of the common cold the late Wm. B. Brown[1] and his associates of the Division of Health Education, Stephens College, Columbia, Mo., gathered statistical evidence as to the value of ascorbic acid in the prophylaxis and therapy of common cold infections.

Bergquist[2] and Glazebrook[3] and others had previously alleged that in their hands administration of large doses of ascorbic acid daily not only reduced the incidence of common colds but shortened by half the average number of work days lost by each patient who developed this infection. The Stephens College data were collected during 1942-43, for a group of 1,600 girl students. The students were requested to report to the health center at the first recognized indication that a cold might be developing. The initial symptoms were noted and recorded and an examination made. From this evidence an estimate was made of the probable number of hours since the presumed onset.

Alternate students were given either 1 gram ascorbic acid by mouth or without the knowledge of the subject a placebo in the form of 1 gram of citric acid. The subjects were asked to rest, keep warm, retire early, push fluids, take no other medication, and on the following morning to report again to the health center. At this second report an additional gram of ascorbic acid or of the placebo was given. Decision was made as to outcome on the second day, 48 hours after beginning of the management described. Examination at this time revealed that the cold had either not developed or had persisted.

With nose involvements not reported until 8 to 28 hours after presumed onset 21 per cent of the cases were spontaneously checked in the group given citric acid and 59 per cent checked in the group given massive doses of vitamin C. This is a difference of 38 per cent of all cases in which the infection was apparently aborted by large doses of ascorbic acid.

Brown suggests no theory to account for this therapeutic effect. He calls attention to the fact that massive doses of ascorbic acid have been reported to increase the ability of animals to withstand traumatic shock,[4] shock due to loss of blood,[5] or to prolonged subjection to the gravitational stress of the upright position.[6] It is a common assumption among European clinicians[7] that the common cold is an initial virus infection complicated in its later stages by secondary bacterial invaders. Accepting this theory, Brown is of the opinion that massive doses of ascorbic

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

acid, while demonstrably effective during the early or virus stage of the infection, would be ineffective during the later or bacterial stage of the disease. In support of this opinion he quotes the fact that ascorbic acid is an in vitro inactivating agent against influenza[8] and poliomyelitis[9] viruses. The vitamin, however, has no reported in vitro deleterious action against pathogenic bacteria. This theory of ascorbic acid therapy will form the basis for further investigation.

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TUBERCULOSTATIC SERUMS

In 1941 Emmart and Smith[1] of the National Institute of Health, Bethesda, Md., described a new technique for titration of the virulence of tubercle bacilli. A standard dose of a suspension of the bacilli was placed on the outer surface of the chorioallantoic membrane of an 8-day-old chick embryo. Six days later the coverslip seal was removed and the membrane fixed in situ with 4 per cent formaldehyde solution. The fixed membrane was placed in Zenker-formol solution and studied histologically. The number of macroscopic and microscopic tubercles and the degree of cellular proliferation were then evaluated. The latter was recorded on an arbitrary scale, 4-plus representing maximum involvement.

As a typical application of this technique Emmart and Smith[2] afterwards tested the attenuating effect of "promin" (p, p′-diaminodiphenylsulfone-N-N′-dextrose sulfonate) on tubercle bacilli. It had been previously reported by Smith[3] and others that this sulfonate administered orally retards the development of the tuberculous process in guinea pigs. To determine the probable mechanism of this retardation, a strain of human tubercle bacilli of moderately high virulence was grown in a routine culture medium (beef bouillon plus 5 per cent glycerine) to which 10 mg. per cent "promin" had been added. After the second transfer in this medium, the strain was returned to the control promin-free culture medium. The exposure to "promin" was repeated from 1 to 4 times, after which the bacilli were again grown in promin-free medium.

To prepare the inoculum a weighed portion of washed bacteria from this final culture was finely dispersed in normal saline solution, 0.2 cc. of the solution contained 1 mg. of tubercle bacilli. In a typical experiment 27 8-day incubated eggs were each inoculated with 0.2 cc. of a suspension of the promin-treated bacteria. An equal number of control inoculations were made with the original non-attenuated culture. Six days later 66 per cent of the membranes inoculated with the promin-treated bacilli showed macroscopic tubercles. There was a 100 per cent involvement of membranes inoculated with the non-attentuated control bacilli. Microscopically the average cellular proliferation was 1.3-plus as contrasted with an average control proliferation of 2.5-plus. These and other data suggest that the virulence of the tubercle bacilli had been reduced approximately one-half as a result of promin-exposure. The exact mechanism of this attenuation was undetermined. In a second series of tests the average degree of virulence was reduced to one-third of the control virulence as a result of slightly longer exposure.

Since then Emmart and Seibert[4] have applied the same technique to a study of the highly controversial subject, the probable rôle of humoral antibodies in tuberculosis resistance. Rabbits were sensitized by repeated intracutaneous injections with purified tuberculin proteins. The serum for such rabbits was mixed with tubercle bacilli and the mixtures implanted on 8-day chick embryos. Control tests were made with normal rabbit serum. In the control tests 94.5 per cent of the inoculated membranes developed macroscopic tubercles. In the sensitized serum tests this number was reduced to 57.1 per cent. In a second series of tests the sensitized and control serums were placed on the membranes 24 hours prior to the inoculation. In this series 64.1 per cent of the controls developed macroscopic tubercles as contrasted with 32.8 per cent in the membranes immunized with the sensitized rabbit serum. The conclusion was drawn from such data that sensitized rabbit serum contains a tuberculostatic factor capable (in the amounts tested) of reducing by one-half the pathogenicity of tubercle bacilli. Fractionation of this serum showed that the tuberculostatic factor is present only in the gamma globulin fraction, the remaining serum proteins being inert.

Examination of pooled serum from patients with minimal tuberculosis showed a similar tuberculostatic factor. This is also present only in the gamma globulin fraction. The relation of this tuberculostatic factor to conventional humoral antibodies has not yet been determined, nor have any clinical applications of the new technique thus far been suggested.

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(References concluded on page 320)

ORIGINAL ARTICLES

Scientific and General

FENESTRATION OPERATION FOR DEAFNESS*

ROBERT C. MARTIN, M. D.
San Francisco

RECENT publicity of a very unfortunate nature has made it imperative that the subject of Fenestration Operation for Deafness be brought into perspective for layman and physician alike. Its background, present status, and probable future will be briefly presented without references to present day technique.

HISTORICAL

Kessel, in 1876, removed the stapes to replace the footplate with a movable membrane. In 1897 Passow trephined the promontory. Both obtained transitory hearing improvement. Barany trephined the posterior vertical canal. Jenkins, in 1913, opened the horizontal canal in two patients and in one used a Thiersch graft.

In 1917 Holmgren used the upper part of the anterior vertical canal, removed the bone between the fistula and the dura allowing the dura to act as the movable membrane. In 1920 he opened the promontory and used mucoperiosteum for a flap. Two years later he opened the horizontal canal covering the fistula with mucoperiosteum of the ampulla.

Sourdille, in 1924, brought new light on the problem by his three-stage technique, which Lempert has modified and converted into a one-stage procedure. Sourdille reported in 1929.

Holmgren[1] was encouraged and changed his technique, obtaining eleven improved patients, eight to a pronounced degree, in thirteen cases. He operated through the mastoid, covered the fistulae with gold leaf held in place by a fat graft and closed the wound.

SOURDILLE'S METHOD

Sourdille's[2] technique was in three stages with intervals of four or five months between. He describes it as follows:

Stage I.—The cutting of and removal of a large area of skin from the outer two-thirds of the postero-superior wall of the external auditory meatus; the healing will take place under this, but strong, epithelialized, hairless and glandless tissue.

Stage II.—The mastoid cells are laid open, the aditus is exposed, and the head of the malleus is removed, care being taken not to dislocate the incus, which must remain in a high position. The cicatricial tissue obtained in this stage—called "plastique interne"—will be used to cover the incus and closes the aditus up to the external semicircular canal. The postoperative treatment will aim at epithelialization as after a radical mastoid operation.

Stage III.—The opening of the bony wall of the horizontal semi-circular canal. The "plastique interne" is applied to cover the opening.

He stresses that only cases with primary otosclerosis with stapes fixation should be operated and indicates one must not wait too long before operating—another way of saying our present dictum that more than twenty decibel loss of nerve function, as measured by bone conduction, should rule out the candidate for operation.

PRESENT STATUS OF FENESTRATION OPERATION

Lempert[3] first published his one-stage, modified, improved Sourdille technique. His later, and perhaps most important contribution to the permanency of the fistula is in placing it forward over the ampullar region of the horizontal canal where a broader fistula may be made. Also his recognition that the incus might be removed without influencing end results in function. He uses the dental polishing burr for the fenestration and European operators used gouges or "rubbers," perhaps another factor he found to insure patency. Minute descriptions of his various techniques are found in the literature and will not be described here. By using them he was able to raise his percentage of good results to around 70 per cent in suitable cases.

INDICATIONS

The type of patient best suited for this operation is a typical otosclerotic, with family history a typical finding. It has been found, however, that many cases not giving such history, but with normal ear drums and absence of previous infection, have responded very well to the surgery. Contraindications are previous infections, sclerosis of mastoid, or nerve type deafness. It must be a conduction deafness, without the contraindications just enumerated.

All of the investigators interested in this work agree that there must be good nerve function to obtain satisfactory results, which is entirely logical. They agree that any patient showing over 20 decibels loss of bone conduction in the hearing frequencies should not be operated. Some operators hold a loss over 40 decibels in air conduction as a contraindication, but we have seen several cases with a loss of over 60 decibels who have obtained rather marked benefit, having had their loss converted into only a 20 decibel loss and bringing them in the range of useful hearing. This particular point is a new question and our own particular opinion is that the nerve factor is the most important one.

RESULTS

The results vary according to the operator's enthusiasm and the criteria used to evaluate those results. To me, there is no result to be considered a result, unless it gives useful hearing to the patient. Perhaps 90 per cent of the cases do show some improvement, but if it does not enable the patient to hear, of what use is the improvement? The figures in themselves are misleading although undoubtedly this was not so intended by the person giving out such a series. I think that a fair estimate of the results to be obtained from trained operators throughout the land will be somewhere in the region of 50 per cent lasting improvement, with the hearing raised to the realm of usefulness. This is a prediction not based on facts, but a recent survey done in the East of 500 cases showed that but 49 per cent obtained lasting useful hearing.

We bring these factors out and mention them because we feel that such articles as recently appeared in the *Reader's Digest* are distinctly harmful, and lead to a loss of confidence in the medical profession because they are misleading in their enthusiasm.

The results will, of course, vary with the skill of the operator, no matter how well trained or how long trained he has been, as it is an exceedingly difficult operation to do and do properly. One must have, in the first place, absolutely accurate knowledge of anatomy and the ability to recognize that anatomy at any time during the opera-

* Read before the Section on Eye, Ear, Nose and Throat, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

tion. In addition, he must possess far more than the average technical dexterity and skill in order to get any sort of a result. As Dr. Mosher remarked recently, it is not an operation for the occasional operator.

COMMENT

There are several factors having to do with this operation that have never been cleared up and will not be until enough cases have been amassed to allow for their proper evaluation. The first one is how long the result of improvement to useful hearing will last. The oldest cases that have been operated are now some six years since operation, and in some cases the maintenance of improvement is remarkable. I have a doctor's wife whom I sent to Dr. Lempert four years ago, who has improved from a 40 decibel loss for air conduction in the hearing range to a ten decibel loss. Her attitude is that if she were to lose her hearing tomorrow, she still feels that the four years of rehabilitation that she has obtained is worthwhile. To be sure, she could have obtained this same result with a hearing aid, but she flatly refused to use one. I can see no reason to suppose that the degeneration of the nerve will be halted by the operative procedure, but Sourdille mentions the fact that in some of his patients many years have elapsed without any apparent progress of the disease evidenced by a loss of hearing. This factor again will have to await the passage of time before it can be evaluated. If Gray's theory of the etiology of otosclerosis is correct; that is, that the nerve change is primary and the bony change is trophic, then of course it will eventually prove that there will be no arrest of the disease by the operative procedure.

REACTIONS OF PATIENTS.

The patient's attitude is one of two things. If he has had a successful result, he is completely rehabilitated, and most of them feel that even though eventually their hearing does progress to another state of uselessness, that the time they have enjoyed normal hearing without the tone distortion hearing aids produce, will have been worthwhile; at least so they state; but knowing human nature, I would like to talk to one after such a secondary recession had occurred. A patient who has obtained an unsuccessful result, that is, he has heard fairly well for three or four months and then there has been a closure of the fistula by bony or fibrous union, is a rather dejected person, usually willing, however, to have a second attempt made to return the hearing to usefulness. I believe that the patient's psychic makeup should be a great factor in determining whether to operate or not, as it is certainly not an operation to be done on a high strung nervous patient who is easily depressed, as in the event of a failure he may suffer a mental trauma which is far worse than the previous deafness from which he suffered. I believe that a thorough physical examination should always be made to determine whether the patient's general condition will stand the shock of such an operation, it being distinctly a major procedure. The main dangers of this major procedure, however, seem to lie not along the lines of mortality but in the occasional occurrence of facial paralysis from an inflammatory spread to the nerve, and secondly, the complete loss of hearing which may result from labyrinthitis after any of the operations. This complete loss, or marked impairment, occurs in from 1 per cent to 2 per cent of patients and is probably nearer 1 per cent.

FENESTRATION OPERATIONS AND HEARING AIDS

What are the advantages of this procedure over wearing a hearing aid, which will produce the same amount of improvement for hearing human speech? There are no advantages if the patient be willing to wear a hearing aid, but most of them will not put up with the inconvenience of batteries and the rather cumbersome apparatus that has to be carried around. Those who have had a hearing aid and then obtained a successful fenestration result, claim that there is no distortion of speech and that the selective amplification of speech over the attendant noises in common every-day life returns immediately that their hearing improvement has become manifest after the operation. This amplification of incidental noises is also one of the chief complaints against the hearing aids. I believe that it is a matter for any individual to have explained fully to him and to allow him to make his choice, the advantages being set forth, and, more markedly than the advantages, the disadvantages should be emphasized. It is, as Shambaugh puts it, an elective operation entirely. The worse ear is usually operated on, and in the event of its loss through misadventure during the operation, there is still a useful ear on which the hearing aid can be used.

IN CONCLUSION

In conclusion, I should like to emphasize that it is the first forward step in doing anything for the deafened that has occurred in my lifetime as a practicing otologist. I am, therefore, very much disturbed at overenthusiasm and injudicious publicity that may endanger a purely scientific approach to the study of whether it is worthwhile or not. I do not believe that the public is capable of judging whether it is or is not, and I think that we should be extremely careful in compiling our statistics before letting them get into print, else irreparable harm will be done to what I feel is an operation of merit.

384 Post Street.

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AMBULATORY PATIENTS AT THE LANGLEY PORTER CLINIC: THEIR MANAGEMENT*

PORTIA BELL HUME, M.D.
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THE term "ambulatory" as applied to patients at The Langley Porter Clinic of the University of California Medical School in San Francisco is a convenient word to designate the patients who are not living in the hospital. Most of the in-patients are, of course, also ambulatory, but their management is on a twenty-four hour basis. This paper deals with out-patients who may merely come for an hour's interview at a time, or who may spend a part of the day in the hospital. The great bulk of The Langley Porter Clinic patients is of this class, for the clinic is built for only a hundred beds, and, up to the present time, but four of the six wards are open due to the shortage of nurses and attendants. In the Out-patient Department, however, during the past six months, there has been a steady average load of

* Read before the Section on Neuropsychiatry, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

From the Langley Porter Clinic, the Medical Center, San Francisco.

about five hundred patients. These cases vary widely in type and age, ranging from behavior problems in children to the psychoses of the aged. Their management, therefore, embraces a number of therapeutic methods to which the psychiatrist, internist, surgeon, psychologist, psychiatric social worker, psychiatric nurse, physiotherapist, and occupational therapist all contribute.

LANGLEY PORTER CLINIC AT U. C. IS A SPECIAL STATE HOSPITAL

The Langley Porter Clinic is a special State hospital established by law to furnish treatment for early and acute mental conditions. The additional functions of the clinic are teaching and research. The practical management of any particular patient, therefore, is not only based on the principles of therapy, but is also related to all three main functions of the clinic. Thus any given patient under treatment may participate in, and benefit from, a program of broader scope than can generally be brought to bear on the problems of mental illness in ordinary practice.

It should be borne in mind also that, while The Langley Porter Clinic is a State hospital, all treatment is on a voluntary basis. That is, no patients may be legally committed to the clinic as they are to other State hospitals. Therefore, whatever the condition and the treatment may be, the patient must clearly understand the plan and voluntarily agree to it. In the long run, this fact limits the clinic to dealing mainly with early cases or with the more benign and curable conditions.

WHEN TREATMENT BEGINS

We consider it important to realize that treatment begins the moment the patient contacts the clinic, either by letter, by telephone, or by walking in the door. Frequently the referring doctor or agency, if there is one, has already made arrangements for the patient. Whether this occurs or not, the primary concern of the entire staff is to create an atmosphere of understanding coupled with a matter of fact recognition of mental or emotional disturbances as illnesses that require medical attention. The psychiatrist is, in fact, often in a position similar to that of the epidemiologist; he may have to remove the patient from the rest of society temporarily, and the spirit in which this is done is identical in the two instances. The common feeling of patients and their families that a social stigma is attached to mental disease is combated by the entire staff, whose attitude is based on a profound conviction that the psychological mechanisms and emotional conflicts of the mentally ill differ in degree, but not in kind, from those of all human beings.

CLINICAL MATERIAL

The kinds of problems handled at The Langley Porter Clinic are as varied as individuals are one from another, but, in a general way, the sources of referral define the main types. About 20 per cent of the cases come from agencies, including courts, probation offices, and schools. Most of these cases have been referred because of abnormal or unusual behavior such as juvenile delinquency, sex offences, addiction to alcohol or other drugs, poor family relations, and bad work-records. In this group there might be included the many veterans referred by the American Red Cross and others after discharge on neuro-psychiatric grounds.

Approximately forty per cent of our patients are referred directly to The Langley Porter Clinic by doctors. Add to this another twenty per cent transferred to us by the University of California Hospital. Generally speaking, all of these patients suffer from physical symptoms and present the dual problem of diagnosis and treatment.

The remaining twenty per cent of patients are self-referrals, a most welcome and hopeful group; for the patient who recognizes in his difficulties the psychogenic nature of the trouble has, in most instances, already taken an important step toward recovery. The most unfavorable members of this group are the faddists and hypochondriacs who spend their lives shopping around for medical services.

Another unfavorable group of patients is referred to The Langley Porter Clinic by distracted relatives, doctors, or agencies. These patients are the hopeless social misfits, the severely retarded mentally, or patients in the advanced stages of mental disease. In such cases, little or nothing can be done for the patient and, furthermore, the patient wishes little or nothing to be done. Here therapy is often aimed at the well-wishing sources of referral, to help them achieve a more realistic acceptance of the patient's poor prognosis, while arrangements are made for hospital or institutional care of the patient.

CHILDREN AND ADOLESCENT GROUP

The children and adolescents range in age from one to seventeen years. The most severe cases of primary behavior disorder or childhood schizophrenia are given treatment in the wards, one of which is set aside for children under twelve. The less disturbed children and adolescents are treated in the Out-patient Department, but in practically all of these cases a major part of the treatment is directed at the parents. In the usual case under eighteen years of age, not only does the patient have his or her own therapist, but also another member of the staff is assigned to one or both parents. The psychiatrist in charge of the Child Guidance Clinic supervises and integrates the work of the doctors, clinical psychologists, and psychiatric case workers who are assigned to the particular case. Thus, while the mother is having interviews with a psychiatrist or social worker, the child may follow a schedule of individual play therapy. Or, for example, an adolescent girl may need group therapy while intensive, individual treatment is indicated for the father and the mother. When a child's relationship to the school is prominent in the problem, a special effort is made to interview the child's teacher so that the clinical and schoolroom programs for the child may be fitted together.

The same sort of coöperative effort by several members of the staff is frequently made for adults as it is for juvenile patients. However, the majority of adult, ambulatory patients are candidates for intensive, individual therapy only. The plan of treatment, of course, depends on the diagnosis, which is made in each case only after complete physical, neurological, psychiatric, and serological examinations. No patient is treated at The Langley Porter Clinic without these examinations, to which in many cases are added psychological, electroencephalographic, x-ray, and special laboratory tests. Free use is also made of the consulting staff of internists, surgeons, gynecologists, pediatricians, and so forth. The patient's mental illness is, therefore, viewed with medical perspective from the outset, and the fallacy of the old dichotomy between organic and functional disorders is minimized. Diagnostic clinics are scheduled by the Director of the Out-patient Department three times a week. Here new patients are seen, a diagnostic impression is reached, and plans for further study at the clinic, or other dispositions, are made. Patients who arrive without appointment and emergencies are handled by the officer of the day and a senior consultant.

PSYCHONEUROTIC GROUP

The largest diagnostic group of patients is the psycho-

neurotic, for which some form of psychotherapy is prescribed. Since the staff members are by no means adherents to any one school of thought, most of the recognized brands of psychotherapy are practiced at The Langley Porter Clinic. A special effort is made to match the patient with the right therapist, but it is likewise considered important not to transfer a patient from one doctor to another any more than can be avoided. Though every patient is seen by a senior consultant, a special doctor-patient relationship is encouraged in all ways.

TREATMENT

While the most important part of the management of ambulatory psychiatric patients consists in individual, psychotherapeutic interviews, other forms of treatment are used concurrently. Group therapy for adults is just being started at The Langley Porter Clinic, though it has already proved useful with children. Occupational and recreational therapy within the clinic are reserved for the in-patients due to shortage of personnel, but help is frequently given the out-patients for drawing upon the community's resources in these fields.

Many clinics frown upon the use of electric shock therapy for out-patients. With the proper precautions, however, this type of treatment has proved to be a safe procedure in about one hundred cases at The Langley Porter Clinic. In addition to obtaining an adequate history from both the patient and a relative, plus complete physical and mental examinations, the following safety measures are taken: (1) An electrocardiogram, if the patient is over forty or gives a history of cardiac disease; (2) x-ray films of the spine, both before and after treatment; (3) an x-ray film of the chest, because, according to some authorities, a tuberculous lesion may be reactivated by shock therapy; (4) the patient must remain in bed for two hours after each treatment; (5) the patient may not leave the hospital alone or drive an automobile, but must be called for by a responsible person; (6) someone must remain with the patient at all times, because of the risk of suicide.

Before curare was used at the clinic routinely, about twenty per cent of patients receiving electric shock incurred fractures of the spine. Most of these were small compression fractures of the upper plate of the vertebra and would have been overlooked without extremely close scrutiny of the spinal films, and in many cases the patient had no symptoms from the fracture. However, because of this large percentage of injuries, the policy of giving curare routinely was instituted. Since that time, the fracture rate has dropped to zero per cent. The dosage of curare is 3 cc. the first time and may be gradually stepped up to 5 cc. if necessary.

The schedule for electric shock therapy is three times a week until apparent recovery. Treatment may not be discontinued at this point, but may be tapered off gradually after the disappearance of the symptoms, with the idea of preventing their recurrence. There is no rigid formula for this part of the treatment which is actually individualized. In general, though, after the initial intensive course, two treatments are given the first week and one treatment the second week, followed by a treatment once in two weeks, then once in three weeks. Patients who display a tendency to relapse are kept on a maintenance dosage of one treatment every two or three weeks, over a period of three or four months, according to the individual problem. This is done especially in cases giving a history of regular cyclic depressions, with the aim of breaking up the cycle.

In all cases, the families of shock patients are warned about the memory defects which usually last a few days to a few weeks after a course of treatment, but which may persist in a minority of cases for several months.

Most of the patients who are given electric shock therapy at The Langley Porter Clinic have been diagnosed as the depressed type of maniac-depressive reaction, as involutional melancholia, or as catatonic schizophrenia with depressive features. We do not consider anxiety states with depression as suitable cases for electric shock therapy.

All patients are followed for at least a year after shock treatment. During that period they receive psychotherapy if this is at all feasible, but at any rate psychotherapy is instituted as soon as, or before, the initial course of shock therapy is begun.

In using the conditioned reflex treatment for alcoholism, it is not possible to give the full course of treatment on an ambulatory basis. The patient must be hospitalized for the initial series of five to eight daily treatments. Following this, however, the single treatment once in two weeks, then once in three weeks, four weeks, etc., may be managed on an out-patient basis. The purpose of the treatment is, of course, to develop a physical aversion to the sight, smell, taste, and very thought of alcoholic beverages, at the conditioned reflex level. This is accomplished by the use of emetine in a delicate, yet rigorous, procedure involving the drinking of all sorts of liquors. It is so rigorous that precautions must be taken to prevent collapse, and the patient must remain in bed for the remainder of the day.

It should be borne in mind, in connection with the treatment of alcohol addiction, that the conditioned reflex treatment constitutes only a part of the general management of such cases. It does not replace psychotherapy or combat the social and environmental factors which are of supreme importance in the problem of alcoholism.

Vocational problems are frequently associated with mental illnesses. The Psychology Department of The Langley Porter Clinic is particularly interested in guidance for such patients and works with the State Bureau of Vocational Rehabilitation, the United States Employment Service, schools, courts, and other agencies in both measuring and treating the patient's vocational difficulties. The clinic does not engage in vocational guidance, however, as a separate function, any more than it accepts a patient solely for an electro-encephalogram or psychiatric case work or any single service. On the contrary, all the special services that the clinic is able to provide are considered as integral parts of the complete study and treatment of the total personality.

The psychobiological principle of the parallelism and inseparability of mind and body lies at the basis of any understanding of the dynamics in psychosomatic conditions. The medical staff of The Langley Porter Clinic practices medicine and not psychiatry as a separate profession. This policy is encouraged, and the effort is fortified, by the fact that the University of California Hospital and Medical School are so closely associated with the clinic. It was established by the State Legislature that the Medical School's Division of Psychiatry should function at the clinic. Thus the two institutions and their personnel have a common bond. In the management of psychiatric patients this bond helps to unify treatment and to remove any doubts about psychiatry's being a fundamental part of medical practice. In this way, both practically and theoretically, The Langley Porter Clinic avoids the illusion of separateness and escapes the delusion that any mentally ill person can be handled as either a purely organic or a purely mental problem.

1st and Parnassus.

Life can only be understood backwards; but it must be lived forwards.

Soren Kierkegaard, *Life.*

CALIFORNIA STATE BOARD OF MEDICAL EXAMINERS*

FREDERICK N. SCATENA, M. D.
Sacramento

IN the year 1876, the legislature of the State of California established itself as a pioneer leader in the matter of legislation regulating the practice of medicine, for it was during that session that an act was passed directing the duly incorporated Medical Society of the State of California to elect a Board of Medical Examiners from its membership. This Board was authorized to issue licenses to all having a valid diploma from a legally chartered medical school in good standing.

In 1901, the legislature, in order to meet the rapidly changing conditions resulting from the ever increasing population and development of the State, made a drastic change in the personnel of the Board. In that year the Board took on a composite complexion with three groups represented: Non-sectarian Doctors of Medicine; Homeopathic Doctors of Medicine, and Eclectic Doctors of Medicine. The Board was authorized to examine and issue licenses to qualified graduates of these three schools.

In 1907, a further change was made necessary, because in that year Osteopathy was legally recognized in California as one of the healing arts, and a Doctor of Osteopathy was added to the composite Board. This Board functioned in like manner as the previous Board.

In 1922, by an initiative act, the People of the State of California authorized the creation of a separate Board of Osteopathic Examiners, and a separate Board of Chiropractic Examiners, each assuming and administering all matters pertaining to their respective schools. A good deal of confusion exists as to types and scope of osteopathic licenses. There is an Osteopathic Physician's and Surgeon's license issued to graduates of recognized osteopathic schools who hold the degree D.O. This certificate entitles the holder to do major surgery and to use any type of drug in the treatment of his patients. Incidentally such a practitioner is not required to use the suffix "D.O." The other type of license is that granted to Osteopathic Physicians. This license has not been issued in late years. It is a limited license, restricting the recipient from doing surgical operations, or giving drugs.

PRESENT LAW: EXISTING BOARD OF EXAMINERS

The present Board of Medical Examiners for graduates in non-sectarian medicine, is composed of ten physicians and surgeons, each appointed by the Governor to serve for a term of four years. The authority under which the Board of Medical Examiners functions is derived from the Business and Professions Code which, by legislative act in 1937 was condensed into its present form. In essence, the present law is what was formerly the Medical Practice Act, adopted in 1913.

In the California Business and Professional Code are tabulated all the requirements for licensure exacted for each branch of the healing arts coming under its jurisdiction, namely: Physicians and Surgeons, Drugless Practitioners, Chiropodists, Midwives and Dispensing Opticians. In the Code will also be found a definition of that which constitutes an offense against the Act, the method of citation and trial, as well as the degree of punishment permitted, I would recommend that this Code be read by all practitioners. It is printed in the directory mailed to you each year when you pay your annual license fee.

During the past five years, the Board has had to consider many unusual problems; most of them resulting from the changed conditions which have come about because of the tremendous movement of people to certain areas where the large plants for the production of war materials are concentrated. This wholesale dislocation of population has caused a disruption in the normal medical coverage for those areas.

REASONS FOR SOME EXISTING PROBLEMS

Public officials and others concerned with the care of these people have sent calls throughout the East, inviting and imploring medical graduates to come to California. Our Chambers of Commerce, through their modest propaganda concerning the beauties of our climate and the opportunities to be found here, have assisted in arousing many physicians to such a pitch that they have closed their offices, sold their homes and have come to California, thus giving up the cumulative results of many years of hard work that were needed to build up a practice. Some of the older men have taken this opportunity to realize a long cherished dream of spending their last years of life in this State, where they hope to find peace and the solace promised them.

In California areas where medical care has become inadequate, the Procurement and Assignment Committee has had the task of supplying the requisite physicians. The difficulties for the Board of Medical Examiners have arisen because its members have had to insist that every individual practicing medicine in these communities should possess a valid license to practice in California. It has been difficult to convince the medical administrative heads of essential industrial projects of the fact that the laws of the State of California have not been suspended by the war effort, important as the war effort is. Therefore, insistence on obedience to these laws has created dissatisfaction and sometimes bad feeling. Also a medical officer, who has served in the Medical Corps of the United States Army for two years and has received his honorable discharge is much annoyed and given to sarcastic criticism upon hearing that his unaccredited school of graduation is still an obstacle to licensure in California. He and many others labor under the erroneous belief that service in the Armed Services erases all deficiencies to be found in their credentials.

RELATIVE NUMBER OF WRITTEN AND RECIPROCITY EXAMINATIONS

The fact that California, to many, has become the Promised land is attested to by a consideration of the comparative figures of the number of written examinations given, and the number of oral (or reciprocity) examinations granted, each for the period from 1940 to 1944, as outlined below:

PHYSICIAN'S AND SURGEON'S APPLICATIONS FILED

For Year	Written Examinations	Reciprocity Oral Examinations	Total
1940	407	262	669
1941	409	309	718
1942	457	333	790
1943	584	471	1,055
1944	402	688	1,090
Total for Five Years	2,259 written	2,063 oral	4,322

Applications for a physician and surgeon certificate increased by 421 or 62 per cent in the last five years.

From these figures it will be noted that the number of written examinations (which represent largely our recent American graduates), has remained fairly con-

* Read before the First General Meeting, at the Seventy-fourth Annual Session of the California Medical Associatoin, Los Angeles, May 6-7, 1945.

From the Office of the Secretary, California State Board of Medical Examiners.

CERTIFICATES ISSUED TO FOREIGN GRADUATES

Year	Written Examinations	Percentage of Foreign of Total Issued	Reciprocity, Inclusive National Bd.	Percentage of Foreign, of Total Issued	Total
1940	33	8%	5	2%	38
1941	34	8%	3	1%	37
1942	38	8%	7	2%	45
1943	19	4%	15	3%	34
1944	11	2%	19	3%	30
Total	135	6%	49	3%	184

Total number of licenses issued in last five years to foreign graduates is 4 per cent of total number of licenses issued.

stant; the great increase is found in the reciprocity group, where an increase of 62 per cent has occurred.

RE: FOREIGN GRADUATES

I have frequently been asked if the influx of physicians into our State is not largely composed of foreign graduates. The following figures for the last five years, compiled for my use by Chief Clerk Wallace Thompson in our Sacramento office, illustrate vividly just what relationship this group of applicants have to all other types:

It will be noted that 184 foreign graduates have been licensed during the last five years. For the same period 3,549 Physician's and Surgeon's licenses were issued. While the number of foreign graduates licensed is only about 4 per cent of the total, it is apparent from the figures that an increasing number of reciprocity applicants are appearing, these having increased from 5 in 1940 to 19 in 1944. The explanation of this trend is found in the fact that these foreigners are now becoming American citizens and are thus removing some of the obstacles to licensure in this State. It is safe to predict that we will see an ever increasing number of such applicants in the succeeding years. This fact is more significant, when we consider that New York State during the last five years has licensed approximately 2,965 refugee doctors. We are receiving applications from South America, Mexico, Canada, Russia and all the European countries, China, Hawaii, the Philippine Islands and Alaska.

The foreign graduate has always been a problem. In 1935 legislation was adopted in California, exacting additional qualifications of graduates of foreign schools. One of these conditions requires that they must complete one year of rotating internship in an approved hospital in the United States. This has proven to be a valuable requirement because it has given the foreign graduate an opportunity to become acquainted with our hospitals and methods, and has been a means of weeding out the poorly trained foreign graduate, since in many instances the hospital has reported unsatisfactory work, and our Board is authorized to exact a satisfactory internship. Thus we are able to deny the privilege of written examination when such applicants present their credentials for consideration.

Some of the difficulties encountered have their pathetic side. I recall the case of a young man of Jewish origin, who completed his medical training at the University of Hamburg, Gremany. He wrote his thesis, passed the examination for a license, and when he was about to receive his degree, the Hitler government decreed that no one of Jewish origin could henceforth receive the degree of M.D. from a German university. In this example, we have a man who possessed all the required medical training, but who had not actually received a degree M.D., nor did he possess a diploma. We were thus obliged to deny him the right to written examination.

After examining many credentials of foreign graduates, I am impressed with the fact that our American medical schools offer a much better course of training, and that our average American graduate is a much better trained doctor upon graduation than is the average foreign graduate.

IMPOSTORS

In the examination of credentials we must be on the lookout for the unscrupulous impostor. Illustrative of this is the case which occurred in 1942 in Chico, California. An individual falsely obtained by correspondence with the Alabama Board of Medical Examiners and the University of Tennessee School of Medicine, a copy of the credentials of a Dr. J. H. Phillips, who had been confined to a hospital for the mentally ill in Augusta, Georgia, since World War I. This impostor was able to obtain employment as a physician in a C.C.C. Camp and later brazenly entered private practice in Chico, under the name of Dr. J. H. Phillips. The result of the investigation by our Special Agent was used by the Federal authorities and the impostor, Arthur Osborne Phillips (correct name) is now resting in McNeil Island penitentiary.

Another case occurred last year, when a colored sergeant in the United States Army presented a photostatic copy of what he claimed was his diploma from the University of Edinburgh. Our investigators, who are practiced in evaluating credentials immediately noted that it was not a genuine diploma, as his name appeared to have been superimposed. By correspondence with the University of Edinburgh it was soon established that no such man had ever graduated from that institution. The strange fact remains that this man had convinced his superior officer in the Army of his qualifications and the latter had written a letter in his behalf.

PENDING LEGISLATION

At the present session of the legislature, the legislative committee of the Board has had to be ever watchful of the many bills introduced, which, if passed, would have distinctly lowered the standards of medicine. All of these are attempts by holders of limited healing art licenses: Drugless, Chiropodists and Chiropractors, each group desiring to extend the scope of its practice. Thus the Drugless practitioner would be permitted to do minor surgery, prenatal examinations, repair obstetrical tears. The fact that their curriculum does not offer surgery as a course does not enter the legislative picture. The Chiropodist would advance from the ankle to the knee, and the Chiropractors, adding a few courses to their present curriculum, would wish to be empowered to issue "Chiropractic Physician's and Surgeon's" licenses.

The total number of physicians and surgeons holding licenses in California on May 1, 1945, was 15,168. Of these there are approximately 4,126 in the Armed Forces. Of the remaining 11,042 perhaps 1,900 are not in active practice in this State, so that we have in round numbers, abuot 9,142 Doctors of Medicine in active practice in the State, as of May 1, 1945.

IN CONCLUSION

The members of the Board of Medical Examiners are cognizant of the responsibilities placed upon their shoul-

ders. The State of California has placed the matter of medical standards squarely upon them, and I can assure you that the Board members have made every effort within their power to administer their responsibility in a fair, honest and unbiased manner. They have always striven to maintain the highest standards of medical efficiency, and they have felt in so doing they not only discharge their obligation to the State, but also repay a debt which they owe to those of our fellow physicians who have given up all to go to the defense of our country.

R 536, 1020 N Street.

A CENTRAL MEDICAL REGISTRY: SOME THOUGHTS REGARDING ITS NEED*

JOHN MARTIN ASKEY, M. D.
Los Angeles

THERE exists at present in medicine a regrettable wastage of clinical experience which can be corrected only by some system of voluntary registration. I refer to the failure of the profession to utilize the vast wealth of experience of its members, particularly with respect to unusual phenomena.

There are many puzzling clinical conditions, supposedly unusual, which are puzzling largely because relatively few data are available for study. The detailed statistical, and clinical analysis of large numbers of cases is the only way many conditions can be studied. The raw material necessary for the analysis of many so-called unusual phenomena is available if it is searched for. "Unusual" and "rare" are relative epithets. A phenomenon may be rare in the experience of any one individual; it may be rare in the experience of an institution; it may be rarely described in the literature. Neither the incidence in one individual's experience nor in the experience of a group, nor its frequency in the literature represents the true incidence. Only a knowledge of the numerical occurrence in the totaled clinical experience of the profession can establish the rarity of any phenomenon. The medical literature represents probably the clinical experiences of 1 per cent or less of physicians, the articulate few. The experiences of clinics or of large hospitals, although valuable, still may represent only a small percentage of the potential material represented in the body of medical practitioners. The experiences of these others, the silent 99 per cent, are urgently needed.

WHY A CENTRAL MEDICAL REGISTRY FOR REPORTS OF SPECIAL CASES?

A central medical registry offers the way by which many conditions can be studied, and if it is not established, the literature ten or twenty years from now will continue to designate as rare many phenomena which are rare only because the profession has been indolent in its interest. The challenge and the problem is how to bring this collection about. There has been little encouragement for the isolated observations of the practicing physician. The only outlet for unusual reports, aside from the local medical meetings, is publication in a journal. Too often such a proffered report is returned because it is a single case report and presumably inconclusive. There has grown up in medicine a certain humorous, but not altogether wholesome condemnation for the man with "a case." The folly of this is that it often patronizingly discards the bricks for the structure of medicine. The man with "a case" possesses a potential solid building stone for increasing knowledge. Medicine is builded upon facts, facts carefully observed, carefully compared, and carefully analyzed. These facts, these building stones, must be collected, screened, and utilized. To do this, there must be a workable mechanism with incentive and interest in the program on the part of the profession and of the individual physician.

A system of voluntary medical registration would be successful because of the natural interest of the attending physician in his particular unusual case. The desire for contribution to medical knowledge exists in every physician and asks only for encouragement and opportunity. If a central medical registry for singular clinical phenomena existed, reports of such experiences undoubtedly would be submitted. Why is there indifference to such clinical wastage? Probably the first reason is simply an unawareness of the magnitude of the clinical returns. Second, a certain institutional clannishness and rivalry is not helpful. Institutions are often reluctant to merge their reports with others. A few cases reported by a single institution or individual may be interestingly presented, but may discourage many other reports. Medicine would be served better if these reports had been added to all the others, and deductions had been drawn from the study of many rather than the study of a few. Many erroneous clinical pronouncements could have been avoided in the past if deductions had been based upon a large, not a small, series of cases. Assertions by authorities can never replace the compilation of facts. The successful mechanism for a program of medical registration must necessarily be evolved, not created. It obviously is dependent upon the continuing interest of the profession as a whole and the encouragement of the individual physician. Perhaps a page in a medical journal might be devoted in each issue to the program. It could keep the physicians continually apprised of the conditions being investigated and encourage reports. Study and preparation of the data could be done by a committee interested in the particular subject. Since the program is concerned with unusual phenomena the collected data would not be prolific. The program should start slowly. The study would be reported as that of the organization with credit and recognition given the contributing physicians and not the editing committee. It is not an impossible nor apparently laborious scheme. Voluntary medical registration can be successful.

A PARTICULAR INSTANCE

This was illustrated a few years ago by a study made by the California Heart Association. An unusual cardiovascular complication reported only once in the literature was found in eight verified instances in the pooled clinical experience of the membership of the association. These can hardly be phenomena peculiar to the State of California, but they would have remained unnoticed without a search. It is certain that a similar search in other states would reveal as many more. The collection of these data would make several hundred case reports available for study where a single instance was on record before. This experience in regard to this one apparently rare clinical phenomenon must apply to many others. The mysterious association of fibroma of the ovary with hydrothorax, or Meigs Syndrome, curable by surgery, is of equal interest to the surgeon and the internist. At present it is reported sporadically, usually in single case reports. There are less than fifty cases in the literature. The etiology is unknown. The syndrome needs further study.

s conditions exist at present, the data will accumue slowly. We shall probably be confronted each year

* Chairman's Address. Given General Medicine, at the Seven of the California Medical . A May 6-7, 1945.

with several reports of two cases each, in which the complete literature and findings of the syndrome are minutely and repetitively reviewed. By this method, the collection of enough cases adequately to study the syndrome may cover a decade or two.

The experience of every doctor in the home and at the bedside will be available to medicine only if and when the profession recognizes this hidden wealth and is willing to go to the trouble of mining it. It is inevitable that in the future a central medical registry will be established. Whether it be fostered first by local, state, or national organizations, such a means for utilizing the vast clinical resources now being thoughtlessly wasted must come. Edith Wharton, in a poem about Vesalius dying on the island of Zante, represents him as saying, "There are two ways of spreading light. To be the candle or the mirror that reflects it. There still remains to spread an answering surface to the flame that others kindle." The medical schools, the research institutions, and the large hospitals may be the candles spreading the light of medicine, but the vast body of practicing physicians is the mirror. If this reflecting surface be neglected, the flame's illuminating power will suffer.

1930 Wilshire Boulevard.

COMMON RECALCITRANT DERMATOSES*

John L. Fanning, M.D.
Sacramento

ONE feels at times, following attendance at meetings and scientific discussions, that too much stress was given to some obscure untreatable polysyllabic name, and not enough discussion on the every day management of refactory, recurring, more common skin disorders.

Chronic recurrent dermatophytosis of hands and fingers, recurrent or unimproved acne vulgaris, lichen planus, and dermatitis of external ear canals are examples of this daily group seen in clinic and office. The first two mentioned will be discussed in more detail.

The most prevalent is, I think, the chronic recurrent dermatitis of fingers and hands. The majority of these patients have made the rounds of practitioners, roentgenologists and dermatologists, who may have applied many and varied forms of local medication, and nearly all have received the limit, or near limit of superficial x-ray therapy, with added ultra-violet therapy.

There is a definite group of these recurrent cyclic type of dermatophytids, some perhaps with a superimposed contact or chemical (over-treatment) dermatitis, but distinctly not as a group, contact affairs, bacterids, or recalcitrant pustular types, described in the literature.

The usual history is the appearance, for several years, especially in summer, of a few scattered vesicles on the fingers, the first attack subsiding quickly. The second attack, a few months later may be more resistant, longer in duration, more eczematoid in nature, with clearing after two or three x-ray treatments. Each subsequent attack becomes more persistent until the skin never completely returns to normal. This group, often exposed to various local occupational irritants, sometimes patch test positive, still show recurrences, even when the irritant is removed.

Most of these patients present clinical signs of a chronic dermatophytosis of toes, feet, or toe nails, some not at the first examination, but usually all on repeated examinations, at some time during the warm summer months.

TRICOPHYTIN EXTRACT

Since 1934 I have been routinely using a stock trichophytin extract as a test and for treatment for certain resistant cases. Despite the poor and adverse reports in the literature,[1] in my hands there seems to be a distinct place for specific trichyphytin desensitization. The initial dose is small, the increase in dosage slow, the interval between doses is a week, later two to four weeks. The injections are continued, even after the injections do not show a positive reaction, after the desensitization seems complete. The local medication used was boric acid ointment or a mild tar ointment. All patients were instructed to avoid soap and water and to wear lined rubber gloves.

I have reviewed some 38 chronic, treatment-resistant cases in office practice, and found: 12 failures; 10 patients slightly improved; and 16 patients clinically cured, except for a minor spring or midsummer exacerbation of five to seven days, which was controlled easily with a single injection, and a bland ointment. Interesting, again was the observation, that except during this minor annual recurrence, all patients could follow their usual occupations, using soaps and other irritants. In this group were two medical men, four barbers, two nurses, four beauty operators, attorneys and housewives. The aggravation of the condition, with its loss of time from office and work, were of marked economic importance to all persons in this group.

The patients called improved were those not followed more than six months; but who were free of the disease at the time last seen. A total of 16 cases have been followed for two to ten years, and have been rechecked at intervals.

The 12 failures were noted in patients who had received much previous x-ray therapy, four showing changes of mild to severe radio dermatitis on fingers and hands. This observation is in agreement with others,[2] that cases previously given x-ray treatment were more slow in response to desensitization.

Here I wish to make the plea that these patients be given little or no x-ray therapy, or at most two or three (5OR) doses carefully spaced, and at the proper clinical time of subsidence of vesicles. This dosage will result in more benefit than many weekly doses; for in this small group, the percentage of minor to major skin changes due to excess x-ray dosage is far too high. Certainly we must be on guard, for these individuals, like psoriatics, soon learn that x-ray treatment controls their exacerbations faster than other forms of therapy, and they are often persistent in their demands for more treatment.

I am not asking for a revival and wholesale injection of trichophytin extract, but do feel that it is a distinct aid in selected chronic, resistant, cases, and that the immunologic approach is perhaps the most rational.

ACNE VULGARIS

It has been estimated that approximately 80 per cent of acne vulgaris will clear and remain well, following usual standard type treatments, including drying lotions, diet, regulation, and superficial x-ray therapy.

It is the 20 per cent of unhealed or recurrent acne who present the same problems as did the first group described. These patients have also received the limit or near-limit amount of superficial x-ray therapy, vaccines, and other treatments with indifferent results. Many are depressed or melancholic, self-conscious, stay-at-home persons.

In the past [illegible] months I have treated 11 such patients,

* Chairman's Address. Given before the Section on Dermatology and Syphilology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

all females, ages 16 to 22. All had previously received three to eight months standard treatment as described above, and all, clinically, were severe acne cases. Two patients showed mild dryness and slight atrophy of skin, suggesting again the limit of x-ray therapy.

VITAMIN A

Three years ago, following the reports of one of our previous chairmen, I began the use of larger doses of vitamin D. My results were poor and indifferent; so I was vitamin shy, until another article by[3] on larger doses of vitamin A revived my interest.

The patients in this group were given 150,000 units of vitamin A daily for three months, together with staphylococcus toxoid (Lederle) in small weekly injections, intradermally. No local medication was given, but in weekly sessions, evacuation of pustules and comedo extractions were done in all patients. Three patients were unimproved in two months, and did not return for further treatment or observation; eight have shown complete recovery in two to six months; two patients have an occasional pustule at menstruation periods. These eight patients have been rechecked after 12 months, and still remain acne free. Two showed marked gain in weight, averaging seven pounds per month. Here, further clinical study is needed and in a much larger series of cases.

I make the plea of discontinuing x-ray therapy, unless marked improvement is seen long before the borderline dosage is approached. Perhaps many patients may not need any form of light therapy, and we may have a means of controlling acne without the hazard of actinic dermatitis.

In final summary, your chairman is desirous of stimulating more clinical reports in our meetings, with reference to management of these and other common dermatoses. This final plea is that decreased amounts of superficial x-ray therapy should be given to the average individual patient. Perhaps, in a few years, other measures may force radiation in the distant background.

1127 Eleventh Street.

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2. Robinson and Grauer, Arch. Dermat. & Syph., 32:787-794, November, 1935.
3. J. V. Straumfjord, Northwest Med., 42:219-225, August, 1943.

CEREBRAL VASCULAR ACCIDENTS: THEIR EFFECT ON THE STATE OF CONSCIOUSNESS*

CLARENCE W. OLSEN, M. D.
Los Angeles

THE classical types of cerebral vascular accident are hemorrhage, embolism and thrombosis. The consequences are hematoma, infarct and encephalomalacia, lesions which obviously result from escape of blood out of vascular channels or from impairment of blood flow. Inasmuch as gross occlusion or rupture of cerebral vessels are seldom demonstrated in pathologic material, there is an increasing interest in functional vascular changes such as vasospasm and vasoparalysis.

Anyone who keeps himself informed of recent clinicopathologic and experimental observations will know that escape of blood into the brain or cerebrospinal fluid, or elevation of intracranial pressure short of systolic blood pressure do not necessarily cause loss of consciousness. Even the obstruction of a major cerebral artery or the rapid destruction of a sizable segment of brain tissue may cause defects in certain fields of consciousness only, rather than inevitable and total loss of consciousness. It would be interesting to discuss these anomalies in detail, but it is better to use this space in making clear what mechanisms do result in loss of consciousness, and how they operate in cases of cerebral vascular accident.

We are all acquainted with the generalization that embolism is a matter of seconds, hemorrhage of minutes and thrombosis of hours, until the appearance of paralysis and unconsciousness. It soon occurs to anyone who sees many autopsies that the clinicopathologic correlation outlined needs some revision if accurate diagnosis is to be made. The author wishes to indicate the general lines along which revision is now possible, by discussing cerebral vascular accidents from the standpoint of consciousness.

CONSCIOUSNESS

Consciousness is a complex function comprising sensation, perception, association and memory. It may be qualified as clear or clouded, intact or defective. Evidence from cases of trauma, infection, neoplasm and vascular lesions points to the upper midbrain and adjoining thalamus as the center for regulation of consciousness. Because of its location in the tentorial notch this region is vulnerable to displacement and distortion by pressure transmitted from remote as well as adjacent lesions. According to Scheinker[1] venous engorgement with edema and hemorrhage is an important factor in disorganizing the midbrain and consequent fluctuation in consciousness. The proximity of a lesion to the midbrain, and the rapidity of its expansion determine the stage at which consciousness is affected. When an extensive lesion occurs in or immediately adjacent to the midbrain, loss of consciousness occurs early, masking other clinical symptoms. A lesion affecting more remote parts of the brain results in vertigo, nausea, vomiting, headache and paresthesia or paralysis perhaps with loss of consciousness later on.

Focal lesions which do not affect the midbrain cause deficits of consciousness by interfering in greater or lesser degree with sensation, perception, association and memory in particular fields. The patient shows lack of insight into his impaired functional state at first, but in most cases he sooner or later grasps the situation.

In one common clinical type of cerebral vascular accident there is abrupt loss of consciousness which persists from a few minutes to hours or days, clearing gradually with more or less severe residual defect of cerebral function, or terminating fatally with no evident lesion other than one or more poorly circumscribed areas of softening, remote both from vital centers and from the center of consciousness in the midbrain. It has been customary to designate such episodes as expressions of arteriospasm.

Although Raynaud's discovery of local syncope and asphyxia with arteriospasm was extended by Osler to explain cases of transient paresthesia, paralysis and convulsion, the status of spasm as an etiologic factor in cerebral vascular accidents is not clear. Vasospasm is a possible cause of one type of syncope resulting from carotid sinus stimulation. It may have to do with migraine and epilepsy. With hypertension, particularly in toxemia of pregnancy, acute lead poisoning and acute glomerulonephritis transient cerebral crises with convulsion and coma, occur as symptoms of vaso spastic encephalopathy. In these conditions permanent paralysis is rare.

When in cases of advanced arteriosclerosis one ob-

* Chairman's Address. Given before the Section on Neuropsychiatry, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

serves sudden loss of consciousness, more or less prolonged coma and more or less extensive residual symptoms, it is more difficult to conceive a spasm, considering the rigidity of the arteries. While Weiss[2] seems to recognize no connection between syncope and apoplexy, such attacks do suggest cerebral anoxia accompanying general syncope and asphyxia, resulting from abrupt vasodepression. Even with a normal vascular tree focal lesions may follow cerebral anoxia in extreme cases. The presence of narrowed, tortuous and irregular arteries predisposes to higher incidence and different distribution of irreversible lesions. There is uncertainty in these cases as to the presence of thrombus or hemorrhage at the onset, but it is known that damage of blood vessels by anoxia can cause capillary thrombosis and diapedesis, causing a picture characteristic of gangrene or infarction without gross evidence of arterial or venous occlusion.

STATE OF CONSCIOUSNESS IN RELATION TO DIAGNOSES

When the effect on the state of consciousness is used as a diagnostic point in cases of cerebral vascular accident, there are four complicating factors which may vitiate the interpretation: sleep, withdrawal, convulsion and concussion. Thrombosis of cerebral vessels frequently occurs during sleep, and the resulting paralysis may be present on waking, or appear after an interval as long as a few hours. The patient's personal reaction to illness may materially affect his responsiveness to tests for consciousness. A convulsion precipitated by an irritant focal lesion may become generalized, with loss of consciousness and subsequent clouded state. A fall incident to the onset of paralysis may result in concussion with more or less prolonged coma.

CONCLUSIONS

1. The escape of blood into the brain or cerebrospinal fluid, and increased intracranial pressure incidental to cerebral vascular lesions do not necessarily cause loss of consciousness.

2. One proved cause of unconsciousness is distortion, edema or hemorrhage in the midbrain affecting the center of consciousness.

3. Focal lesions of the brain cause defects in various fields of consciousness but do not result in stupor or coma unless the midbrain is affected by direct extension or transmitted pressure.

4. Another known cause of unconsciousness is cerebral anoxia due to arrest of cerebral circulation, the result of vasospasm or vasodepression.

5. Cerebral anoxia causes unconsciousness within a few seconds. This syncope may be recoverable or irreversible, with or without focal residuals.

6. The diagnostic value of loss of consciousness with cerebral vascular accidents is vitiated when sleep, withdrawal, convulsion or concussion enter into the picture.

1136 West Sixth Street.

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Tuberculostatic Serums—Additional References

(Continued from Page 310)

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(Continued from Page 360)

lister, Mill Valley; Middough, Long Beach; Niehouse, San Diego; Price, Upland; Robertson, Santa Barbara; Stephenson, Elk Grove; Stewart, Pasadena; Stream, Chula Vista; Thompson, San Jose; Thorp, Lockeford; Waters, Los Angeles; Watson, Orange; Weber, Stockton; and Werdel, Bakersfield.

Absent: Denny, Etna; Sawallisch, Richmond; Thomas, San Pedro.

* * *

Report of Action on Other Legislation of Interest to Date Follows:

Chiropractic

Assembly Bill 111—Authorizing Chiropractors to do premarital examinations—resting in committee.

Assembly Bill 236—Making chiropractors physicians and surgeons—killed on the floor of the Assembly.

Assembly Bill 1519—Qualifying chiropractors as "physicians" under the Labor Code relating to workmen's compensation. Passed Assembly. Amended in Senate to provide that chiropractor does not have any right or is not entitled to represent, advertise or hold himself out as a physician. Passed Senate, signed by Governor.

Assembly Bill 1610—Permitting Chiropractic Board to issue a directory—passed the Assembly and the Senate.

Chiropody

Assembly Bill 1089, Assembly Bill 1546, Assembly Bill 1929—Requiring one member of Board of Medical Examiners must be a chiropodist—killed in committee.

Assembly Bill 1928—Requiring one member of State Board of Public Health must be a chiropodist—passed Assembly, died in Senate Committee.

Senate Bill 1047—Creating California Chiropody Society—killed in committee.

County Hospitals

Assembly Bill 1111, Senate Bill 218—Opening County Hospitals to pay patients—died in committee.

Dentistry

Assembly Bill 1598—Establishing Division of Dental Health in the Department of Public Health—approved by Assembly Committee on Public Health—now in Ways and Means Committee.

Drugless Practitioners

Assembly Bill 1240, Senate Bill 1004—Changing term "drugless practitioners" to "drugless physicians"—both bills killed in committee.

Herbalists

Assembly Bill 1678—Placing herb practitioners under Board of Medical Examiners—killed in committee.

Hospitals

Assembly Bill 502—Carrying out provisions in Proposition No. 4 on November ballot—passed Legislature and signed by the Governor.

Assembly Bill 600—An act to accept benefits under Federal Hospital Construction Act—now before Ways and Means Committee in Assembly.

Assembly Bill 601—Licensing, inspecting, regulating and supervising public and private hospitals—passed Assembly and approved by Senate Committee.

Senate Bill 295—Authorizing county hospitals to join hospital associations—passed by the Legislature and signed by the Governor.

Senate Bill 586—Permitting establishment of hospital districts—passed Senate.

Industrial Accident

Assembly Bill 1702—Authorizing Commission to adopt fee schedule—still in Senate Committee on Finance and Insurance.

(Concluded on Page 365)

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

HOUSE OF DELEGATES: CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Forty-second (42nd) Annual Session of the House of Delegates of the California Medical Association*

First Meeting, Sunday Noon, May 6, 1945, in the Elks Temple and Auditorium of the Los Angeles County Medical Association Building

SPEAKER ASKEY: The House will be in order. The delegates of the California Medical Association here assembled in the Elks Temple, are called for the convening of the 42nd annual session of the House of Delegates. Is the Chairman of the Credentials Committee, Dr. Foster, ready to report as to whether a quorum is present?

DR. FOSTER: I have in my hands registration cards for 72 regularly elected delegates to the California Medical Association. I move you that these be constituted as delegates to the convention.

SPEAKER ASKEY: You have heard the report of the Chairman of the Credentials Committee that 72 members of the House are in attendance, which constitutes a majority. The Chair rules that this report of this Committee be accepted as the roll call.

SPEAKER ASKEY: Is there discussion? If not, all in favor of this ruling, say aye, opposed no. The motion was unanimously carried.

The House is now duly in session.

At this time the Speaker will declare a recess for the purpose of taking care of necessary secretarial duties and preparing of agenda. The end of the recess to be called at 2:00 o'clock, and the convening of the House out of recess shall be at the Los Angeles County Medical Association Building, at 1925 Wilshire Boulevard.

Recess

The recessed meeting of the House of Delegates came to order at 2:15 P.M., Sunday, May 6, 1945, in the Auditorium of the Los Angeles County Medical Association headquarters building, Speaker, E. Vincent Askey, presiding.

SPEAKER ASKEY: The House will be in order, please. We have a lot of business to transact and we must get at it. This is the recessed meeting of the House of Delegates which was convened this morning at the Elks Temple.

I am going to call on the Chairman of the Credentials Committee, Dr. Paul D. Foster, to report if there is a quorum present. Dr. Foster!

DR. PAUL D. FOSTER (Chairman, Credentials Committee): We have present 103 qualified delegates to the House of the California Medical Association.

SPEAKER ASKEY: You have heard the report of the Credentials Committee that there is a quorum present. The House will be in order.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

At this session it is not necessary to have the Roll Call, if someone will move that the Report of the Credentials Committee shall constitute the Roll Call.

. . . It was moved, seconded and carried that the Report of the Credentials Committee would constitute the Roll Call at this session. . . .

SPEAKER ASKEY: Motion is carried. This recessed session is now in session.

Reference Committees

The first item of business is the appointment by your Speaker of various committees, which are designated by our By-Laws.

The *Credentials Committee* consists of the following members:

Paul D. Foster, Chairman
B. R. Simpson
Jesse L. Carr

Reference Committee No. 1 which has to do with Reports of Officers and Standing Committees is as follows:

Paul A. Quaintance, Chairman
C. Glenn Curtis
Roger W. Barnes

Reference Committee No. 2 which takes care of the Report of the Council and the Reports of the Secretary-Treasurer and Executive Secretary is as follows:

A. E. Moore, Chairman
J. Frank Doughty
William Benbow Thompson

Reference Committee No. 3. This Committee has charge of the Resolutions, Amendments to the Constitution and By-Laws and New and Miscellaneous Business:

L. R. Chandler, Chairman
H. J. Templeton
Samuel Ayres, Jr.

I wish to call your attention to the fact that the Chair has the prerogative by the Constitution to assign any business before this House to the Committee that he thinks most appropriate, unless there is objection from the House. That procedure will be followed. It is usually the custom to assign only those things which are so stated in the By-Laws, but there is the right to designate to either committee, so if you will remember that, if I give something to some committee you don't like, you may object.

At this time I want to present to you your President, Dr. Lowell S. Goin, who will give his Presidential Address in addition to the one he gave this morning. Dr. Goin! (Rising applause.)

Address of President Goin

Mr. Speaker, Members of the House of Delegates: The matters before this House are so pressing and the time is so short that I would not have the courage to burden you with another address. I would like to say only two things to you. One, taking advantage of a well-established precedent, I should like to use this rostrum for the moment for a sort of sounding board from which to address the leaders of Labor and the Law Makers of the State of California, and I should like to point out to them that the insincerity of their purpose in improving the public health is clearly shown by their current proposal to include chiropractors in health care to the public under the proposed compulsory health bill. No person can argue sincerely that the chiropractor has anything whatever to contribute to public health and care of our people when ill. This addition to the bill is obviously a political maneuver to assure double strength and this will just confirm a point I made this morning, that their motive is not improving the health of the people but it is a political maneuver looking toward a socialized dictatorship

If the Governor and the Legislature of this State sincerely wish to improve the health of the people there are many ways they could do it without enacting the compulsory health bill. They could, for example, edit radio advertising on patent medicine, vitamins and so forth. They could cease licensing cultists. They could put on an educational program to persuade people that there are no secrets in human knowledge; that all knowledge is public and that everything known by the profession can be looked up by anyone who has the background necessary to understand it, and that cults and secret methods are simply silly.

The second thing I would like to say to you is that we are faced today with a very grave situation. We do not know whether compulsory health insurance will be enacted or not. We do not know whether, if it is is defeated, it may not come to the attention of the electorate on the ballot at the general election. If there is an initiative or a referendum, we do not know whether or not it can be defeated. Certainly we mean to try.

If there is one thing that is needed for our success in this campaign it is a united medical profession. I wish to beg this House of Delegates to take no action today or tomorrow which would in the slightest degree impair that unity and which would give the enemies of medicine the slightest opportunity to point to a divided profession which cannot even make up its own mind on these vital questions. Let us bear in mind in all of our relations the urgent necessity for unity, for a common front, and for a united profession standing firmly for what the profession believes to be right. Thank you.

SPEAKER ASKEY: At this time your speaker wishes to make a couple of announcements and see if we can clarify things a little bit.

In the first place, Dr. Peers, who is a Trustee of the American Medical Association, wants me to call your attention to the fact that the meeting of the House of Delegates of the American Medical Association has not yet been decided upon due to transportation difficulties. He has a telegram here from Dr. West which says:

"Filed application for permission of the meeting of the House about two weeks ago. Have not yet received any word from the Office of Defense Transportation. Asked for July 23 to 25 but those dates are not available. May be given permission for meeting at a later time. Will advise promptly when permission is received."

Therefore, so far as the American Medical Association House of Delegates' meeting is concerned, the time of meeting for this year is not set.

There is one thing your Speaker wishes to explain. Due to difficulties in transportation many of the members of our House of Delegates have found it difficult to be present at this meeting. With a view to considering that, some suggestions were made some time ago that the voting procedure of this House should be along the method of some ratio of votes of different sections of the State as regards the actual voting, so that an equitable representation from each part of the State could be had, irrespective of the difficulties in transportation. You received some letters in regard to that and then you received a subsequent letter telling you that any delegate who came would be seated. That was for the following reason. Under our Constitution and By-Laws there is no method by which the Constitution of the House of Delegates can be changed except by constitutional amendment, which would take a year, laying over for discussion in the meantime. Therefore, any delegate duly elected who presents himself to this meeting must be seated. He is entitled to his vote. However, since there has been so much discussion, it has been deemed wise that an equitable and a right decision as to the method

of voting in this House should be arrived at. The Constitution says that every man shall be allowed his vote, but he isn't required to vote; in other words, if you don't want to vote, you don't have to.

Therefore, I am going to appoint a committee to think over that, and to present ways and means deemed desirable to this House tomorrow. In view of the fact that the session today is given over, as you know, to the introduction of resolutions and very few actions can be taken, if any, today, it will give you 24 hours to think over this problem. I am going to appoint the following special committee consisting of Dr. Frederick C. Bost, Dr. Louis J. Regan and Dr. George W. Walker of Fresno. If this committee will get together this afternoon and evening and present to this House some equitable plan for their consideration, we will take it up at tomorrow's session.

Reports of Officers

At this time we will have the *Report of the Council.* Dr. Philip K. Gilman.

DR. PHILIP K. GILMAN: Mr. Speaker, may I ask the privilege of having this report postponed for a few minutes in order that additional matters which were considered at the meeting of the Council yesterday afternoon may be put in proper form for presentation?

SPEAKER ASKEY: If there is no objection from the House, it will be granted.

The next will be the *Report of the Trustees of the California Medical Association,* Lowell S. Goin, President.

DR. LOWELL S. GOIN: There is nothing additional to report.

SPEAKER ASKEY: There being nothing additional to be presented the Report of the Trustees will be presented to Committee No. 1.

(NOTE.—All reports were referred by Speaker to one of the three Reference Committees, according to their nature.)

The report of the *Auditing Committee,* Dr. John W. Cline, Chairman. Do you have anything additional?

DR. JOHN W. CLINE: No additional report.

SPEAKER ASKEY: Next is the *Report of the Secretary-Treasurer.* Do you have anything additional, Dr. Kress?

SECRETARY GEORGE H. KRESS: No additional report.

SPEAKER ASKEY: There being no additional report, as these have all been published in the Annual Reports Bulletin, the Report of the Secretary-Treasurer will be referred to Reference Committee No. 2. I wish to call your attention to the fact that if there are no additions to these reports, the ones standing in here will be the ones which will be referred to the committees.

Report of the Executive Secretary. Is there anything additional, Mr. Hunton?

MR. JOHN HUNTON: I have an additional report.

ADDENDUM TO REPORT OF EXECUTIVE SECRETARY

Mr. Speaker and Members of the House of Delegates: Two items on which your Executive Secretary has been working during the past year were intentionally omitted from the report published in CALIFORNIA AND WESTERN MEDICINE in order that the latest available information on them might be placed before this House. These items are industrial fees and malpractice insurance.

As your Legal Counsel has already reported, the Executive Secretary was named as one member of a ten-man study committee appointed by the *Industrial Accident Commission* for the purpose of arriving at a fair and equitable schedule of medical and surgical fees for compensation cases. This committe has held three meetings to date and will probably hold additional meetings in the future. As a member of the committee I wish to report that in my opinion the insurance men who comprise the main body of the committee are not in any way interested in arriving at a fair, equitable and complete schedule of fees, but are concerned primarily with a delaying action designed to maintain the present insurance company system of buying medical and surgical services in a competitive market, no matter what ill effects that type of buying might have on the medical profession. Since the committee was originally named, additional members representing the osteopathic profession and the American Federation of Labor have been added to the group. It is possible that these additional members—both of whom are supporting the efforts of the California Medical Association to secure more adequate fees for compensation practice—may result in exerting a beneficial influence on the committee. However, it is my opinion at this time that the net results of this committee will be negligible. With your approval, I will continue as a member of this committee and will do everything possible to try to effect some progress toward fair and equitable fees for this type of practice.

In the matter of *malpractice insurance premiums,* your Executive Secretary was instructed last year to survey the methods in use in other states in securing proper malpractice insurance for association members at fair premium levels. This survey was started last fall and replies from thirty state medical associations have been received. Some of these are not complete enough to furnish the desired information but most of them will be useful in determining the experience of other states.

Unfortunately, several months' time was required before a sufficient number of replies had been received to furnish a working basis for our survey, and by the time these replies had come in the central office found itself in the middle of the compulsory health insurance legislative battle. All other work, including the malpracitce insurance survey, was dropped in favor of this legislative work, and so the insurance survey has not been completed.

It is possible to report that there are some extremely interesting possibilities shown in some of the state medical association replies, particularly in the field of group coverage with coöperation between the insurance carrier and the medical association in the matter of defense of suits or threatened suits. The state medical association in Washington, to cite one specific example, has developed a program which shows great possibilities.

This survey will be completed at the earliest possible date and a report made to the Council and the House of Delegates at that time.

SPEAKER ASKEY: The Report of the Executive Secretary with the addition will be referred to Reference Committee No. 2.

The next is the *Report of the Editor.* Is there an addition, Dr. Kress?

SECRETARY KRESS: No additional report.

SPEAKER ASKEY: Next are the *Reports of the District Councilors and Councilors-at-Large.* Are there any additions to the published reports of the Councilors? If any Councilor has an addition, he is privileged at this time to make it. Hearing no additions to any of the reports, the Reports of the District Councilors and the Councilors-at-Large will be referred to Reference Committee No. 1.

The next is the *Report of the General Counsel,* Hartley F. Peartt. Mr. Peart!

REPORT OF THE GENERAL COUNSEL

MR. HARTLEY F. PEART: Mr. Speaker and Members of the House of Delegates—I will supplement very briefly my report published in the *Pre-Convention Bulletin.* Since dictating that report we were advised that the

State Board of Equalization had amended one of its rules seeking to impose a *sales tax on x-ray film* used by radiologists in making diagnoses. At the direction of the Executive Committee, we have taken up this matter with counsel for the Board, taking the position that under the standard practice of radiologists these really form part of their records and are never sold as personal property. Agents of the Board have in some localities furnished application blanks to physicians requesting they take out retail licenses and that matter is now in a lively state of flux at the present moment. We have just rendered a rather comprehensive opinion to the Association on the subject.

Regarding the *Industrial Accident Commission Fee Schedule*, which was dealt with in our report, we would like to say further that a hearing has been fixed on Assembly Bill 1702, introduced by Assemblyman King, at which time Dr. MacDonald and I are scheduled to appear before the Assembly Committee on Insurance. The bill presented only a few of the matters which the Council felt should be suggested for legislative action but the turmoil aroused by the compulsory health proposals restricted our suggestions.

In the case of the *California Physicians' Service*, again the Insurance Commissioner, which is dealt with in the report, has brought up this matter. This was decided, as you may recall, by Superoir Judge C. Julian Goodell of San Francisco, in the first instance, holding that C P.S. was not engaged in the corporate practice of medicine and was rendering medical service and not doing an insurance business. This decision was upheld by the District Court of Appeal. Since the publishing of our report, the Supreme Court, on the application of the Attorney General, has granted a hearing.

We briefly mentioned *compulsory health insurance*, as stated in the report, and in mentioning it my mind goes back to the fight in 1918, some 27 years ago. At that time I had the honor of representing you. A united profession then, after a vigorous campaign, defeated this proposal by a two to one vote in every county of the State.

The next big legislative onslaught on scientific medicine occurred in 1922 when the initiative, one by the osteopaths and one by the chiropractors, came up at the general election in that year. In the interest of public health and professional standards, the profession was strongly opposed to both of these measures but it was divided as to the conduct of the campaign; in fact, it was thoroughly disunited on this vital matter. The result was a defeat which has had a bad effect on public health and has caused embarrassment in legislative matters ever since.

The last example was an effort to enact the Basic Science Act. Because of these two, the initiative and the Basic Science proposal, it had to be in the form of an initiative and not an act of the Legislature.

In the present crisis, where the issue again is an acute one, compulsory state medicine, the courage, determination and united action of the profession makes us, if you will permit me to say it, proud, indeed, to represent you.

SPEAKER ASKEY: The additional report of the General Counsel, Mr. Peart, will be referred, in addition to the published report, to Reference Committee No. 1.

We will now return to the Report of the Council, Dr. Philip K. Gilman, Chairman.

* * *

ADDITIONAL REPORT OF THE COUNCIL

DR. PHILIP K. GILMAN, Chairman: Mr. Speaker and Members of the House of Delegates—

Resolution Re: The American Cancer Society

WHEREAS, The American Cancer Society has requested the "approval and assistance" of the C.M.A. and its aid in having component county societies establish "Prevention Clinics," the C.M.A. makes the following statement:

The California Medical Association is aware of the constant increase in the ravages of cancer, and is deeply concerned with the prevention and cure of this disease. The Association heartily endorses all serious attempts directed toward early diagnosis and adequate treatment and directs attention to the following considerations:

1. Early and accurate diagnosis of cancer is essential if the disease is to be controlled.
2. Such diagnosis may require quite extensive facilities including microscopy and x-ray studies.
3. Tumor clinics sponsored by the American College of Surgeons are in existence all over California and these clinics have easy access to the special services required.
4. The C.M.A. urges any person who suspects that he may be suffering from cancer to seek out his private physician or such tumor clinics and to present himself for examination.
5. These tumor clinics make no charge for services and the members are not paid. The only cost to the patient is a small fee (usually about fifty cents) to cover stenographic and record expense.

In view of the foregoing, it is the opinion of the California Medical Association that the establishment of so-called cancer prevention clinics is unnecessary; and, it is therefore

Resolved, That the California Medical Association therefore declines to endorse them.

* * *

Resolution Re: Prepayment Medicial Service Plans
Supplemental Report

WHEREAS, California Physicians' Service has always been and is now earnestly attempting to provide prepaid medical care for the largest possible number of people; and

WHEREAS, It is of the greatest importance that the generous and whole-hearted support heretofore afforded California Physicians' Service of California continue; now, therefore, be it

Resolved, That the Council of the California Medical Association urges the House of Delegates to endorse California Physicians' Service; and, be it

Further Resolved, That the Council of the California Medical Association advises and urges this House of Delegates to make no change in the present form of California Physicians' Service.

SPEAKER ASKEY: The first resolution which was presented by Dr. Gilman from the Council will be referred, with his written report, to Reference Committee No. 2.

The last resolution, having to do with C.P.S., will be referred to Reference Committee No. 3.

The Report of the Council, as a whole, will be referred to Reference Committee No. 2.

Reports of Committees

We come now to the *Reports of the Standing and Special Committees*. You have before you the names of the Committees, and, as I call them, if the Chairman has any addition to make to the published report, if he will call it to the attention of the Chair, I will give him the floor; otherwise, it will be considered that he has no further report to add.

A. Standing Committees:

Executive Committee—John W. Cline.
Committee on Associated Societies and Technical Groups—John V. Barrow.
Committee on Audits—John W. Cline.
Committee on Health and Public Instruction—J. C. Geiger.
Committee on History and Obituaries—Morton R. Gibbons, Sr.
Committee on Hopitals, Dispensaries and Clinics—Roy E. Thomas.
Committee on Industrial Practice—Donald Cass.
Committee on Medical Defense—Nelson J. Howard.
Committee on Medical Economics—Glenn F. Cushman.
Committee on Medical Education and Medical Institutions—B. O. Raulston.
Committee on Organization and Membership—J. F. Doughty.
Committee on Postgraduate Activities—F. E. Clough.
Committee on Publications—George W. Walker.
Committee on Public Policy and Legislation—Dwight H. Murray.
Committee on Scientific Work—George H. Kress.
Cancer Commission—Harold Brunn.

If there are no additions, these reports, as published,

will be referred to Reference Committee No. 1.

Dr. F. E. Clough: We are very anxious that post-graduate activities be tied up with post-graduate activities for veterans and all things of that nature. I would merely like to say that during the past year we used up practically all our red points in getting nowhere and there was not even enough red points left to put on a state-wide program.

Speaker Askey: Your attention is called to the remarks made by the Chairman, Dr. Clough.

We come now to the Special Committees:

B. Special Committees:

Committee on Physicians' Benevolence—Axcel E. Anderson.
Committee on Industrial Fee Table—Hartley F. Peart, Esq.
Committee on Maternity-Pediatric Plan of Federal Children's Bureau—Karl L. Schaupp.
Committee on Participation of the Medical Profession in the War Effort; Procurement and Assignment Service—Harold A. Fletcher.
Special Liaison Committee on Medical and Hospital Plans in California—John W. Cline.
Advisory Committee to the California Bureau of Vocational Rehabilitation—John W. Cline.
Liaison Representative to California Veterans' Committee—Frank A. MacDonald.
Committee on Postwar Plans of Medical Service and Social Security—Dewey R. Powell.
Proposed Changes in the Industrial Accident Commission Fee Schedule—Nelson J. Howard.
Liaison Group to A.M.A. Council on Medical Service and Public Relations—Dwight H. Murray.

Are there any additions by the Special Committee Chairmen? If not, they will be referred to Reference Committee No. 1.

At this time we are going to interrupt the published agenda of this meeting and introduce to you a man who is to speak to us on a subject which is of great importance to the California Medical Association.

I wish to introduce to you Mr. Clem Whitaker, who has been directing the publicity and the fight against compulsory health bills. Mr. Clem Whitaker.

Report to the House of Delegates

Mr. Clem Whitaker: Mr. Speaker and Members of the House of Delegates—Political prophecy is always dangerous, but I believe it is safe to predict that no compulsory health insurance legislation will be enacted at the present session of the Legislature. That forecast, however, is predicated on the assumption that a continuing, aggressive campaign against compulsory health insurance will be conducted until the final gavel falls and the Legislature adjourns.

The fight has just broken out again in Sacramento, as you know, and the proponents of State medicine are reported to have put aside their differences and joined forces in an attempt to get the Assembly to reverse itself and adopt a bill.

The forces against us are formidable and powerful, for they include not only Governor Warren, with all the prestige and influence which the Governor's Office commands, but also the C.I.O., the State Federation of Labor, the Parent-Teacher Association, the League of Woman Voters, and several metropolitan newspapers which are militantly crusading on this issue.

Earlier in the session, both the Warren and C.I.O. bills were refused approval by the Assembly Public Health Committee and were then rejected by the Assembly itself on a motion to withdraw the bills from Committee.

That is an eloquent tribute to the effective work of the medical profession, and the able and aggressive leadership of the officers and staff of your Association in getting the facts before the Legislature and the public and in alerting the people to the danger of a politically-controlled medical system.

The Assembly vote, especially on the Warren bill, was exceedingly close, however; 39 "No" to 38 "Yes," and we are deeply indebted to the many lodges, civic and veterans' organizations, business and farm groups, and a large section of the press for the support which made victory possible.

We all have our work cut out for us to hold the lines during the remainder of the Legislative Session but I believe further attempts to pass a bill can be defeated, despite the tremendous pressure which is being brought to bear on the Legislature by the Warren-C.I.O.-A.F.L. coalition.

The end of the Legislative Session, however, will not end the agitation for State medicine in California.

The medical profession will have won a reprieve, rather than vindication.

The members of your House of Delegates, I am sure, are fully cognizant of the situation.

It would be risking eventual disaster to let the present confused state of public opinion continue, or to ignore the problem except when the issue is forced by the foes of private medicine.

An Affirmative Campaign

Irrespective of what action the proponents of compulsory health insurance may take this year or next, the issue must be faced and there must be a clear-cut decision which will silence the critics of the medical profession and put an end to the constant agitation for State medicine.

That will require more than just defensive action on the part of the California Medical Association.

It will require affirmative action to make prepaid medical and hospital service available to all the people on a voluntary basis, so that the problem will resolve itself, and so that the proponents of government medicine will be stripped of all effective argument for their program of compulsion.

That is an ambitious program but it is not an impractical or impossible program. It can be done and must be done, if the medical profession is to escape ultimate regimentation. In a later section of this report we will discuss how it should be done.

Before attempting to oultine a plan for future action, I believe a frank appraisal of both the probable and possible political contingencies which lie ahead is in order.

First, it is probable that the Legislature will adopt a resolution, providing for an interim legislative committee to investigate the whole problem of compulsory health insurance and voluntary systems, with instructions to report back to the 1947 session.

Second, it is possible that the Legislature will refer the question to the people by submitting a Constitutional Amendment to the voters similar to the amendment which appeared on the 1918 ballot.

Third, it is probable that the C.I.O., with the support of Governor Warren and other interested parties, will qualify an initiative compulsory health insurance act for submission to the voters, either at a special election this year or at the November General Election in 1946.

By the time the Legislature adjourns, probably about the middle of June, you will have definite information on the first two contingencies, involving the proposed legislative interim committee and the possibility of a Constitutional Amendment. But we cannot know definitely whether the threatened C.I.O. initiative will materialize until the petitions for such an act are circulated and qualified.

The Best Defense—An Offense

In any event, the same rule applies in politics that applies in the prize rinig. You must be prepared to defend yourself at all times and the best possible defense is still an offense.

Your affirmative campaign should be a campaign to end compulsory health insurance campaigns in California for all time.

It can and should become a crusade which will echo throughout the United States and which will have great impact on Congress, as well as our own State Legislature.

California has been the testing ground for a great many visionary schemes and phony movements, but it has also become the burial ground for most of them.

The voters in this State, after they have heard the issue debated, can usually be depended upon to vote wisely and there need be no hesitancy on your part in facing a showdown fight on this issue.

That is the quickest and surest way to dispose of it, so that you can go back to the practice of medicine and leave the practice of politics to the politicians.

If an effective, intelligent campaign is conducted, compulsory health insurance will be consigned to the same fate as the EPIC movement, the Single Tax and the Ham and Eggs pension scheme. But that result can be achieved only by a well-organized, well-financed, all-out campaign, with every doctor on the firing line, and with every facility and resource of allied interests mobilized and utilized to the fullest.

A Three-Way Campaign

We must necessarily provide alternate plans to cope with several possible contingencies as there are still many unknown factors in the situation.

It is the recommendation of your public relations counsel that the California Medical Association authorize and prepare a three-way campaign, extending over a period of approximately two years. . . .

Conclusion

In conclusion, let me say that there has been enough ground work done already in the public phases of our legislative campaign, both in individual contact work and in presenting the issue to civic and business organizations, to determine a great deal concerning public relation on this question.

A State-wide survey of public opinion, involving 3,000 personal interviews, has been completed under the direction of a responsible survey organization.

This survey has produced data of considerable value in convincing the Legislature that the public is unready to accept the type of medical care which would be provided under a system of compulsory health insurance, even should a system be placed in operation. Of the 3,000 people interviewed, 73.7 per cent said if they were compelled to join a State-operated hospital and medical service they would still go to their own private doctor in case of illness. Only 26.1 per cent expressed a willingness to go to the State plan doctor.

It became immediately apparent, as the survey returns came in, that the great majority of the people in California don't want State medicine for themselves, mainly because they fear the poor quality of service they would get under it. This fear of incompetent doctors, inferior service and assembly-line medical methods undoubtedly represents the Number 1 argument against compulsory health insurance with rank and file voters.

With business and civic organizations, however, the most important argument against compulsory health insurance is the tremendous cost involved, plus the feeling that State medicine is simply another form of public ownership, and that other professions and businesses will be taken over by the State if the medical profession is regimented.

You will be happy to know that nearly 200 newspapers in California already have published editorials against compulsory health insurance.

Several hundred civic groups, business, farm, fraternal, veterans' organizations and improvement clubs and religious and political groups, already have taken formal action condemning the compulsory health bills before the Legislature and these organizations will be ready to pitch in and help in a ballot campaign

Perhaps the most effective support we have won during the legislative campaign has been that of the American Legion and the Veterans of Foreign Wars. Their action in demanding that such legislation be postponed until California's 800,000 service men and women are home and able to participate in the discussion rang the bell with both the Legislature and the public at large.

Let me say this to you emphatically, as my final recommendation:

Regardless of what else you do, make common cause with business and agriculture and the veterans and every other interested group in this campaign. Make it a crusade for private enterprise and out of it will come a new Declaration of Independence in California—a resolute declaration against attempts of government to regiment the people.

But to put an end to attempted government encroachment on your profession, you have to prove to the people that the medical profession can do voluntarily what the State says can be done only by compulsion.

I believe you can do it and if you wish our organization to assist you, we will be happy to do so.

Thank you.

Speaker Askey: I think you will agree with me that Mr. Whitaker has laid before you the plan, which, if we will follow it, may be the turning point in the practice of medicine for us or for at least a continuation of what we think is good in the practice of medicine.

Recess for First C.P.S. Meeting

At this time we will go into *Recess* for the meeting of the *Administrative Members of the California Physicians' Service*. We hit it pretty close. You see, it is only three minutes after three and it was to have been at three o'clock.

Unless there is objection then, the Speaker will declare a recess of the House of Delegates of the California Medical Association to come together again and convene after the meeting of the Administrative Members of C.P.S. I hereby declare the House of Delegates in recess.

I will introduce to you Dr. Glenn Myers, Vice-President of the California Physicians' Service. Dr Myers! . . . The House of Delegates recessed and the convening of the members of the C.M.A. House of Delegates, acting as Administrative Members of the California Physicians' Service followed immediately, Dr. Glenn Myers presiding. . . .

(Note.—The minutes of the meeting of the Administrative members are on file in the central office of California Physicians' Service, 153 Kearny St., San Francisco.)

Post-Recess Meeting of the House of Delegates

The House of Delegates re-convened at 3:30 p.m.

Speaker Askey: The House of Delegates of the California Medical Association will not convene out of recess and the House is hereby declared open for business.

At this time we will take up Unfinished Business. The Unfinished Business which is lying on the table is that of Amendments to the Constitution. I wish to call the attention of the House, to refresh your mind, to the procedure in making Amendments to the Constitution and By-Laws of this Association. At any meeting of the House of Delegates regularly called, Amendments to the Constitution and By-Laws may be presented. It is

required that they lie on the table for one year. At the end of that time they shall be voted upon by this House of Delegates. Any Amendment to the Constitution or By-Laws must be voted upon as it was printed and presented without change. In other words, no amendments to the question are allowed. However, for the information of the House, it is customary that the Constitution and By-Law Amendments which have lain on the table be referred to one of our Reference Committees for their advice and interpretation in regard to whether or not they should pass in the opinion of the Committee, and then the vote will be taken. These Amendments which have been presented and laid on the table and which you have seen printed on page 18 of your program will be referred to Reference Committee No. 3. In view of the fact that they have to do with the Council, Reference Committee No. 3 will consider the amendments to the Constitution and By-Laws which have lain on the table for one year.

The Secretary of the House, Dr. Kress, will announce the time and place of the various Committee meetings as soon as the chairmen of the different committees get together and decide upon the time and place

NEW BUSINESS AND RESOLUTIONS

The House is now open for New Business and Resolutions.

Dr. Griggs!

DR. JOSEPH F. GRIGGS (Los Angeles): Thanks to our officers and staff, the public in California is well aware of our laudable opposition to the principles of compulsion but other principles are not well known. We have never taken time in this body to formulate a definite statement of the essential conditions under which we are willing or not willing to serve the people of the State of California.

As a general practitioner in the rank and file, I offer this resolution in the hope that it will afford some impetus in this direction:

Resolution No. I.—Concerning Principles Involved in Medical Practice

For action taken on this resolution, see page 337.

WHEREAS, The adoption of any plan of widespread health or sickness insurance involves great changes in the entire way of life in the practice of Medicine and Surgery; and

WHEREAS, Great changes are sure to involve the sacrifice of some values and conveniences; and

WHEREAS, Conveniences and non-essential values can and should be given up whenever necessary to obtain greater values for society as a whole; and

WHEREAS, It is necessary, nevertheless, to discover, declare and preserve all essential values of the previous or present way of life, with all vigilance and determination in order to prevent sabotage of the new values which the proposed changes are intended to provide; now, therefore, be it

Resolved, That this House of Delegates holds the following conditions to be values of first order consideration, essential to the success of any plan for the ultimate security of society as a whole:

1. The personal-confidential relationship between patient and doctor.
2. Free choice of physician by the patient.
3. The right of the physician to refuse or discontinue service of certain kinds of cases or individual patients and to seek consultation according to the traditional ethical standards of the medical profession.
4. Unhampered medical control of all professional matters.
5. The prevention of any third party, including the State, from receiving unearned increment of profits from the existence or duration of the patient's illness and its treatment.
6. The protection of the physician from an unreasonable amount of paper work, making out reports and certificates in triplicate to various administrative officers, boards, funds and commissions. The doctor's time and effort must be available directly to the sick.
7. The separation of medical benefits from disability cash benefits. Any indemnification for time lost due to illness must be separate, both in origin and in administration, from medical benefits and services.
8. The provision of community care of the indigent and of mental and tubercular diseases.
9. The maintenance of facilities for medical education and research and for the advancement of preventive medicine and public health.

SPEAKER ASKEY: This resolution will be referred to Reference Committee No. 3.

May I call your attention to the fact that your resolutions should be submitted in triplicate and if you do not have them typed in triplicate we will have one of the secretaries do them for you. They must be presented to the Secretary of the House in triplicate.

Are there further resolutions to be presented to this House?

DR. J. M. DE LOS REYES (Los Angeles County): I want to present an Amendment to the Constitution of the California Medical Association.

Proposed Amendment to C.M.A. Constitution. Re: Ex-officio Members of Council

For action taken on this resolution, see below.

Be It Resolved, That the first paragraph of Section 1, Article VII, of the Constitution of the California Medical Association be amended to read:

"The Council shall consist of the Councilors, and ex-officio: The President, the President-elect, the Speaker and Vice-Speaker of the House of Delegates, each with all the rights of a Councilor."

and, be it

Resolved, That the first paragraph of Section 4, Article X of the Constitution of the California Medical Association be amended to read:

"The President, President-elect, the Speaker and Vice-Speaker of the House of Delegates shall be ex-officio members of the Council with all the rights of Councilors."

SPEAKER ASKEY: This is an Amendment to the Constitution and By-Laws and must lie on the table for one year and must be published twice during the year in the *Official Journal*. It is so referred to the Association Secretary to be laid on the table and published as required by the By-Laws.

Are there further resolutions?

Dr. Bruck!

DR. EDWIN L. BRUCK (San Francisco):

Resolution No. II.—Concerning Spokesmen of the American Medical Association

For action taken on this resolution, see page 337.

WHEREAS, The American Medical Association has created a council on public relations, known as Council on Medical Service and Public Relations which council is charged with the responsibility of representing the American Medical Association to the public and governmental agencies of the United States; and

WHEREAS, The presentation of the official point of view of the American Medical Association by other councils, committees and individuals, leads but to confusion and to different and divergent views, with the effect of apparent disunity in the profession; and

WHEREAS, At this time the profession is in need of greater unity than ever before in its history; therefore,

Resolved, That the Council on Medical Service and Public Relations shall be the sole agency for presentation of the attitude of the American Medical Association relative to matters in which the organized profession should or must make representation to the public or to the government; and, be it

Further Resolved, That all Councils, committees, officers and employees of the American Medical Association shall be required to consult with and obtain permission from the Council on Medical Service and Public Relations prior to making pronouncements actually or impliedly in the name of the American Medical Association; and, be it

Further Resolved, That the delegates from the California Medical Association to the American Medical Association introduce the foregoing resolution into, and strive for its adoption by the House of Delegates of the American Medical Association; and, be it

Further Resolved, That a copy of this resolution be forwarded at once to each and every delegate and alternate delegate to the American Medical Association with the request that they too strive for its adoption.

SPEAKER ASKEY: That will be referred to Reference Committee No. 3.

DR. BRUCK: I have another resolution, Mr. Speaker.

Resolution No. III.—Concerning Full-Time Employees of American Medical Association

For action taken on this resolution, see page 338.

WHEREAS, At this time many important problems confront the medical profession and a greater load is placed upon each individual in the profession due to the exigencies of war; and

WHEREAS, The American Medical Association is in need of the most efficient organization possible in the solution of its problems; and

WHEREAS, Employees who participate in activities outside of the Association cannot render their best service to the Association; therefore, be it

Resolved, That all employees of the Association, who are not specifically employed on a part-time basis, shall be required to devote their full time to the activities of the Association for which they are employed and shall not engage in outside activities from which they derive financial income; and, be it

Further Resolved, That the Delegates from the California Medical Association to the American Medical Association introduce the foregoing resolution into, and strive for its adoption by the House of Delegates of the American Medical Association; and, be it

Further Resolved, That a copy of this resolution be forwarded at once to each and every delegate and alternate delegate to the American Medical Association with the request that they too strive for its adoption.

SPEAKER ASKEY: This resolution will be referred to Reference Committee No. 3.

Dr. McClendon!

DR. SAM J. MCCLENDON (San Diego): I have been asked to present this resolution by the majority of the Delegates of the First District.

Resolution No. IV.—Concerning American Association of Physicians and Surgeons

For action taken on this resolution, see page 340.

WHEREAS, The introduction of a system of medical practice commonly called "Compulsory Health Insurance" has been proposed in the State of California, to which system a majority of the reputable physicians of California are opposed for the reason that such scheme can only produce undesirable regimentation and is inimical to the public health of this State; and

WHEREAS, These same ethical physicians desire to unite in an association apart from those of the profession who are willing to subjugate themselves to the dictates of such politically controlled and socialized practice of medicine; and

WHEREAS, Such an association should be national in scope, admitting all doctors of medicine in good standing in their respective State and County Medical Associations into one united association; and

WHEREAS, The American Association of Physicians and Surgeons was founded for this purpose and so functions, embodying principles and ethics which will protect the practice of medicine against the inroads of such compulsory health insurance and socialized medicine schemes, not acceptable to the majority of its members; and

WHEREAS, A majority of the members of the California Medical Association endorse the principles announced and sponsored by the American Association of Physicians and Surgeons; now therefore, be it

Resolved, That this House of Delegates accept and approve the American Associaiton of Physicians and Surgeons, and endorse the principles promulgated by it; and, be it

Further Resolved, That all members of the California Medical Association eligible for membership in the American Association of Physicians and Surgeons be permitted and urged to apply for membership therein; and, be it

Further Resolved, That at such time as the desired percentage of the members of the California Medical Association shall have attained membership in the American Association of Physicians and Surgeons, the proponents of schemes for compulsory health insurance and socialized medicine shall be advised, and the general public shall be informed that its members propose to abide by and accept the principles contained in the Constitution and provided in the By-Laws of the American Association of Physicians and Surgeons.

SPEAKER ASKEY: The resolution will be referred to Reference Committee No. 3.

Are there further resolutions to be presented before this House?

Dr. Regan!

DR. LOUIS J. REGAN (Los Angeles):

Resolution No. V.—Advisory Planning Committee for California Medical Association

For action taken on this resolution, see page 340.

WHEREAS, Many complex problems in the fields of medical economics, public relations and legislation are constantly before the Council and the House of Delegates of the California Medical Association as well as before the governing bodies of the component medical societies for study and decision as to the course of action; and

WHEREAS, Factual information and expert advice must be available if sound conclusions are to be reached, which information and advice cannot be acquired by practicing physicians serving on the governing boards without undue sacrifice of time and effort; and

WHEREAS, The California Medical Association and its larger component county societies and the Public Health League have for many years employed attorneys, executive secretaries and public relations counselors who are thoroughly familiar with the problems confronting the medical profession as well as with the attitude of the public in general: now, therefore, be it

Resolved,

1. That the House of Delegates of the California Medical Association authorize and direct the Council of the California Medical Association to establish and to appoint the Advisory Planning Committee of the California Medical Association; and

2. That the Advisory Planning Committee of the California Medical Association shall consist of Messrs. Hassard, Cochems, Hunton, Ebersole and Read; and

3. That the Advisory Planning Committee shall hold monthly meetings; that the time and place of meetings be designated by the chairman of the committee and such further additional emergency meetings as may be required at the direction of the Council of the California Medical Association; and

4. That the Advisory Planning Committee of the California Medical Association shall be empowered:

A. To study the economic and health factors involved in medical and hospital care problems as presently under consideration or as may be hereafter brought to the attention of the committee;

B. To act in other matters as the Council of the California Medical Association may from time to time direct;

C. To make reports to the Council of the California Medical Association in respect to all of these matters outlining action recommended to be taken, with reasons therefor.

SPEAKER ASKEY: The resolution will be referred to Reference Committee No. 3.

Are there further resolutions to come before this House?

DR. JESSE L. CARR (San Francisco): Mr. Chairman, may I explain this resolution before I introduce it or must it be introduced?

SPEAKER ASKEY: If your explanation is not discussion of it, you may, and if it has something to do with the reason for it.

DR. CARR: It has specifically and I think there should be an explanation on this matter. There are certain elements of humor in it.

SPEAKER ASKEY: If it is real humor, it may be introduced.

DR. CARR: This is positively funny. It has to do with chiropractors and Christian Scientists. I am introducing this first resolution on the Christian Scientists because we in San Francisco in the Coroner's Office really know what goes on inside of the Christian Science places. As you may or may not know, there is a large Christian Science home in San Francisco which bears the title "Home," but which really is a hospital or a dying ground for Christian Scientists who don't want to die at home. In San Francisco sometimes the Coroner's Office insists on autopsies inasmuch as a Christian Science Practi-

tioner is not able to sign a death certificate. The common method among Christian Scientists in San Francisco is to call in a doctor in the last 24 hours or just before the last 24 hours of death. Most of us are suckers enough to go in and sign this death certificate at the last moment.

In the last five years the campaign for the cause of medicine has eliminated some of this practice but not all of it. Just before I came down here, I collected statistics from the Coroner's Office and out of 2,500 autopsies relatively in 1942, 1943 and 1944, we had 63 autopsies on Christian Scientists in 1942; 55 in 1943 and 59 in 1944.

SPEAKER ASKEY: Dr. Carr, I am sorry to interrupt but that is discussion which should come up with your resolution tomorrow. I will have to order that you read your resolution and the discussion will come tomorrow, please.

DR. CARR: The funny part cames later. I would like to say that when these autopsies were done we found epidemic meningitis, diphtheria and tuberculosis.

Resolution No. VI.—Concerning Christian Science Practitioners

For action taken on this resolution, see page 342.

WHEREAS, Christian Science Practitioners are, contrary to their avowed purpose, treading the medically ill, and

WHEREAS, These people are dying unnecessarily, carrying and spreading communicable disease and constitute a public health hazard, and

WHEREAS, It is impossible to safeguard the public health with a proportion of the population acting as uncontrolled carriers of disease, now, therefore, be it

Resolved, That no member of the California Medical Association serve under any compulsory health plan not including Christian Scientists.

SPEAKER ASKEY: This resolution will be referred to Reference Committee No. 3. I believe there are two resolutions.

DR. CARR: The following resolution relates to chiropractors.

Resolution No. VII.—Concerning Chiropractors

For action taken on this resolution, see page 342.

WHEREAS, Chiropractors have inadequate basic science training, their concepts and methods are inadequate, misconceived and dangerous; and

WHEREAS, They constitute a medical menace to public health; therefore, be it

Resolved, That no member of the California Medical Association serve under any compulsory plan including chiropractors.

SPEAKER ASKEY: This resolution will be referred to Reference Committee No. 3.

Your Speaker wishes to call attention to something which the Delegates, I am sure, understand but which is something misunderstood by those who are visiting here. Resolutions of almost every description may be introduced. They do not represent the action of the California Medical Association until after they have been voted upon. Remember, that any resolution today is not the action by the California Medical Association but it is in our democratic procedure that anybody may introduce them for the purpose of discussion only, and it is for that reason they are introduced at this time.

Are there any further resolutions to be presented?

DR. BRYANT R. SIMPSON (San Diego County): The compulsory health insurance bills which have been before this House have created a lot of local discussion in San Diego. There are several things we don't like about the bills, and there are several things we don't like in what we have done about it. The first one is that the bills as developed or presented before this present Legislature have proposed coverage for only a part of the people of the State.

SPEAKER ASKEY: Dr. Simpson, I am very sorry to have to call you, but the discussion on your resolution must be tomorrow. If you will introduce it at this time, please.

DR. SIMPSON: That is true. Thank you. I will apologize for my preliminary remarks, Mr. Speaker.

Resolution No. VIII.—Concerning California Physicians' Service

For action taken on this resolution, see page 342.

WHEREAS, The subject of compulsory health insurance has been forced on the members of the California Medical Association by the Governor of the State of California and by organized labor groups within California; and

WHEREAS, There has been considerable complaint over a number of years that the lower income groups in the State have not been receiving adequate medical and hospital care; and

WHEREAS, The California Physicians' Service and other voluntary plans of health insurance have not been adequate to service the lower income groups within the State and provide them with adequate medical and hospital care; and

WHEREAS, The California Physicians' Service since its inception, has not been able to promote membership within this income group to the point to which it has adequately cared for the medical and hospital needs; and

WHEREAS, The California Physicians' Servcie in its mode of operations is seeking a third party relationship between physician and patient which is contrary to the wishes of the majority of the physicians of the California Medical Association; and

WHEREAS, We have been informed by Legislators that the California Physicians' Service has played no part in the present defeat of the compulsory health bills in the present session of the Legislature; therefore, be it

Resolved, That the Trustees of the California Physicians' Service be advised that we no longer wish to maintain coverage service such as the California Physicians' Service; and, be it

Resolved, That the California Physicians' Service be further instructed to discontinue the selling of side coverage and to devote their entire time to the indemnification of policy holders; therefore, be it

Resolved, That the Trustees of California Physicians' Service be instructed to proceed to convert their present coverage to the plan of an indemnifying type of insurance; and, be it

Further Resolved, That the California Medical Association endorse an indemnifying type of health insurance for the people of California in those low income groups which are unable to the present time to obtain adequate medical and hospital srevices and that this coverage include not only the low income group level but also the indigents of the State.

SPEAKER ASKEY: The resolution will be referred to Reference Committee No. 3.

Are there further resolutions? This is your time. You know, the By-Laws state that a resolution cannot be introduced tomorrow except by unanimous consent, so if you wish to have a resolution introduced, do it now.

If no one else wishes the floor, the Chair at this time wishes to make several announcements.

Will the Chairmen of these three Reference Committees come to the front of the room, to the Secretary's desk, to receive their reports and other items which these Committees are to consider after this meeting?

Reference Committee No. 3, which is the one dealing with the resolutions, which are the ones you will probably want to discuss, will be glad to have you appear before that Committee. That is not only your privilege but you are urged to appear before these committees and argue these points if you have an interest involved.

. . . (Announcements regarding time and place of Committee meetings were made.)

If there is no further business to come before this body, I would like to have a motion that the President of the Association, the Speaker of the House of Delegates and the Association Secretary be appointed a committee to edit and approve the minutes of this meeting.

DR. KNEESHAW: I so move.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

SPEAKER ASKEY: At this time I wish to call your attention to the fact that the next meeting of this House of Delegates will be in this room, at one o'clock tomorrow afternoon. Be here promptly, please, because we wish to get our business over, since those of our delegates who come from some distance may wish to start home as soon as possible.

A motion to adjourn is now in order.

DR. GOIN: I move we adjourn.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

SPEAKER ASKEY: We are adjourned.

. . . The first meeting adjourned at 3:50 p.m. on Sunday afternoon, May 6, 1945.

Second Meeting of the C.M.A. House of Delegates Monday Afternoon, May 7, 1945

The Second Meeting of the House of Delegates of the California Medical Association, 74th Annual Session of the Association and 42nd Annual Session of the House of Delegates, was held in the Auditorium of the Los Anglees County Medical Association Building, Los Angeles, California, May 7, 1945. The meeting was called to order at 1:15 p.m., by Dr. L. A. Alesen, Vice-Speaker of the House of Delegates.

VICE-SPEAKER ALESEN: Will the House please come to order?

The Chair calls upon Dr. Paul Foster, Chairman of the Committee on Credentials, to find out if he has a report to make at this time.

DR. FOSTER: We have 37 or more Delegates present.

VICE-SPEAKER ALESEN: Thank you, sir.

Mr. Secretary, shall we proceed with the Roll Call?

SECRETARY KRESS: Yes.

(Secretary Kress called the roll as listed in the "Pre-Convention Bulletin.")

VICE-SPEAKER ALESEN: If there are no more additions, the Roll Call has been taken and as taken will constitute the House of Delegates.

We will now proceed to the further order of business. Before proceeding, the Chair will recognize Dr. Louis Regan who will submit to the House the *Report of the Special Committee with respect to voting procedures in the House.* Dr. Regan!

DR. LOUIS J. REGAN: Mr. Speaker: On this matter of voting we have not been able to find any ideal solution. The problem is a very difficult one. There is no provision in our Constitution and By-Laws for variation of the course with which we have become familiar and accustomed to year by year.

We have this suggestion to make. We would suggest that when it comes to a vote on any question before the House that we take a straw vote first. That will work provided the particular unit organizations for county medical society delegations are not divided. It will have this advantage and that is that everyone may think and go home satisfied on a particular question. If, in counting the votes, for instance, for Los Angeles County, we would count full representation, no matter how many or how few may be here, and similarly for all organizations and counties in the State, we believe we could work it out. For example, San Francisco may only have six here, but on the straw count we would count the total number of their delegation, which I believe is 24, and then if the results indicate that it would be the same, even if they had every representative here and voting the same way, I believe that would be satisfactory.

Obviously, the procedure just outlined will not work as to controversial issues, or where a county unit is divided. Here the Committee's suggestion is that in dealing with these problems, the straw vote, for instance, doesn't apply where there is a division in the county unit, if there is a controversy. In such cases we could caucus the unit at that time and endeavor to establish a gentlemen's agreement in some way or other to deal with the issue. It seems to your Committee, the matter of a gentlemen's agreement is difficult. In respect to the small counties, what standard may we use and suggest for them? If we raise this to one vote for each 200, some of the small counties would have a fractional vote or no vote; at any rate, there would be an overloading in some center or another. Our purpose has been to try to find a completely fair and equitable arrangement and that we have not been able to do.

These are the best suggestions the Committee has been able to work out.

VICE-SPEAKER ALESEN: Before proceeding with the regular order of business, one of the members, Dr. Charnock, has requested unanimous consent of the House to introduce a resolution bearing directly upon the eminent declaration of V-E Day. Inasmuch as this resolution seeks to place the California Medical Association on record in a favorable light, it is suggested that Dr. Charnock be given the floor for that purpose. If the Chair hears no objection, it is assumed that there is unanimous approval and now, Dr. Charnock, will you proceed?

DR. DONALD A. CHARNOCK (Los Angeles): Mr. Speaker:

Resolution No. IX.—Pledge of C.M.A. to Promote Victory

WHEREAS, The forces of the United Nations have this day brought to a victorious conclusion the first phase of our common titanic struggle, and

WHEREAS, We, of the California Medical Association, realize that the continued efforts of all America must now rally whole-heartedly behind the supreme task of achieving final victory against our remaining enemy; therefore, be it

Resolved, That we, the members of the California Medical Association, at this time solemnly reconsecrate ourselves to a renewed endeavor to bring victory to our armies and peace to the world and by this expression of dedication we honor the three thousand of our colleagues who are engaged in this great war.

Mr. Speaker, I move the unanimous passage of this resolution.

VICE-SPEAKER ALESEN: Is there a second?

DR. GOIN: I second the motion.

VICE-SPEAKER ALESEN: Is there any discussion? If not, you have heard the resolution and all of those in favor signify by saying "aye," opposed "no."

. . . The motion was put to a vote and it was carried unanimously. . . .

VICE-SPEAKER ALESEN: It is the suggestion of Dr. Charnock that the House rise for just a *Moment of Silent Tribute* to our members who are in the Armed Forces.

. . . The members of the House stood in a moment of silent tribute to the members who are in the Armed Forces. . . .

VICE-SPEAKER ALESEN: Mr. Secretary, will you make the announcement appropriate at this time.

Place of Meeting of C.M.A. Session in 1946

SECRETARY KRESS: Mr. Speaker and Members of the House: The Council has selected the City of Los Angeles as the place of the Annual Session for the coming year.

Budget

VICE-SPEAKER ALESEN: Dr. Cline, will you present, as the Chairman of the Finance Committee, the report of the budget at this time?

DR. JOHN W. CLINE: The budget has been previously

published in mimeographed form. There was only one change from the original and the suggested budget. The revenue of the Association, in round figures, is $137,000.00 and the total expense is $118,000.00 in round figures for the succeeding year.

Budget for Calendar Year 1946

I—Estimated Income

	1946 Budget
Membership Dues	$100,000
Advertising Sales	35,000
Journal Subscriptions	800
Reprint Sales (Net)	100
Annual Session	
Miscellaneous (includes earned interest, Herzstein Bequest, etc.)	1,500
Total Estimated Income	$137,400

II—Total Estimated Expenses

Rent	3,288
Telephone and Telegraph	850
Postage	750
Stationery and Printing, Office Supplies, Office Expense	2,000
Salaries:	
(a) Secretary-Treasurer	4,140
(b) Executive Secretary	9,000
(c) Clerical	9,500
(1) Social Security Tax	200
(2) Unemployment Tax	200
Travel Expenses:	
(a) Officers	750
(b) Councilors	3,000
(c) Executive Committee	250
(d) Executive Secretary	1,000
(e) A.M.A. Delegates	2,500
Council-Executive Committee Expense	750
Annual Session	6,000
Employees' Annuities	500
Pensions	960
Dept. of Public Relations	1,000
(a) C.P.S. Promotion	
Cancer Commission	1,000
Committees' Expenses	1,500
Committee on War Effort	500
Postgraduate Committee	2,000
Public Policy and Legislation	13,500
(a) United Public Health League	
Benevolence Committee	5,000
Secretarial Conference	1,200
Donations to Libraries	2,500
Legal Department	5,500
Woman's Auxiliary	200
Equipment Expense	1,000
Miscellaneous	3,000
California and Western Medicine:	
(a) Printing	20,000
(b) Postage and Mailing	2,000
(c) Advertising Commissions	5,000
(d) Discount and Collections	300
(e) Editor's Salary	4,600
(f) Supplies	950
(g) Office Postage	850
(h) Illustrations	600
(i) Doubtful Accounts	250
(j) Addressograph Expense	300
(k) Editorial Board Travel	300
Total Estimated Expenses	$118,688

Vice-Speaker Alesen: You have heard the report of the Finance Committee on the budget.

Dr. Gilman: I move it be adopted.

Dr. James Doyle: I second the motion.

. . . The motion was put to a vote and it was unanimously carried. . . .

Vice-Speaker Alesen: It is so ordered.

C.M.A. Dues for Calendar Year 1946

At this time we shall hear from the Chairman of the Council, Dr. Philip K. Gilman, on the matter of dues for the coming year. Dr. Gilman!

Dr. Philip K. Gilman: Mr. Speaker and Members of the House of Delegates:

With respect to the annual dues for next year, the Council, in submitting its recommendation, has been guided by the following circumstances:

1. Loss of revenue in the past three years due to waiver of dues of members in the armed services to the number of 2,200.

2. Need for adequate funds to aid doctors returning from the armed services and in general to assist during the inevitable disruption of relocation from war to peacetime practice.

3. Need for adequate funds for post-graduate study and refresher courses for doctors whose practice has been restricted to military service or work in war industrial areas.

4. Need for further funds to promote more widespread participation in voluntary medical and hospital pre-payment plans.

5. The necessity of reëstablishing the reserves of the Association which are being constantly diminished by costly national and state public relations activities and increased cost of operations of all the Association's functions.

In view of the foregoing, the Council unanimously recommends that the annual dues for the year 1946 be fixed at $100.00 per member.

I move the adoption and approval of this report.

Dr. Peers: I second the motion.

Vice-Speaker Alesen: You have heard the recommendation fixing the annual dues at $100.00 per member. Is there discussion?

Dr. Earnest Dozier (Shasta County): Mr. Chairman and Members: I have been paying dues in the C.M.A. for nearly 34 years and the dues for many years have been too high. The result of the dues being too high has been too much money to spend on the part of those who are spending it and the result of that has been the hustling of the practitioners of medicine and the doctors of medicine in private practice in this State into adventures in which we have no place.

I listened to the program of what they propose to do for returning doctors. I am a veteran of two wars. I was there when they took Manila the first time and I was in France the last time. Nobody said anything about my rehabilitation. I will take care of myself and they can take care of themselves. We are not all cripples, injured or deficient in any way. The men went to war because they had to do it and it is just what anybody ought to do and they can take care of themselves after the war.

I think $100.00 for membership is absurd. A society organized for the purpose of advancing the skill, the scientific attainments and the general welfare of the private doctor of medicine in private practice presumably still exists for that purpose, although it seems somewhat doubtful and it seems we have a great many purposes which have nothing to do with the practice of medicine, or at least so remotely they can't, without a great deal of effort and a great deal of straining of the mind, be connected up. It appears that membership in the C.M.A. is an economic matter rather than a professional matter.

The trouble with it is that the doctors are more or less at the mercy of those who propose these things and if a doctor doesn't belong to a county medical society they wonder what is the matter with him. Is he off color? Is there anything wrong, any place? Is it a question of insurance and all of those matters and he is practically forced in whether he wants to belong or not; at least there is a great deal of pressure, unless he is of a very independent spirit, and he is apt to grudgingly give up, realizing all of the time that somebody is putting the squeeze on him. It shouldn't be done.

The inevitable end of that thing is damage to C.M.A. There is no question about that at all. The C.M.A. has

already been damaged and badly damaged. We haven't the position in the public's esteem we ought to have, and the reason why is because we have permitted the affairs of this Association to degenerate into a series of economic problems rather than professional problems.

Don't think the mere fact that it cost $100.00 to join a county medical society in this State isn't an indictment. It is bound to react in adverse public reaction. This is really the thing you are trying to avoid.

There are a lot of things that can be said but there is a lot of business to come before this body this afternoon and I think I have made it fairly clear, the reasons why I am opposed to this and the reasons why most doctors of medicine should be opposed to any such idea of that generally throughout the State. I think it will become manifest if this thing is put over.

. . . The question was called for. . . .

Vice-Speaker Alesen: Is there further discussion?

. . . The question was called for again. . . .

Vice-Speaker Alesen: If not, you are voting to set the dues for 1946 at $100.00, in support of the Council's recommendation.

. . . The motion was put to a vote and it was carried. . . .

Election of Officers

Vice-Speaker Alesen: We now proceed to the next order of business which is the election of officers for the ensuing year.

The first officer to be selected is the *President-Elect of the California Medical Association.* Dr. Remmen!

Dr. E. T. Remmen (Los Angeles): Mr. Speaker and Members of the House of Delegates: Now and again an opportunity is given to do honor to an old and esteemed friend, one who has not been only a friend, but a good fellow and who has also risen to a place of eminence in his profession. In such a case it is difficult to find suitable words.

Down in the far southern end of our State where the climate is said to excel even that in Los Angeles, and where they build great airplanes and ships, lives a hard-working fellow who has been a pediatrician for these many years. Beloved by his patients and his fellow practitioners, he has served his colleagues in the council halls of medicine for 20 years.

He is a past-president of the San Diego County Medical Association and is currently secretary of the California Heart Association. He is a member of the California State Board of Health and one of our delegates to the A.M.A. He has made outstanding contributions to the study of rheumatic fever. He will grace the Presidency of the California Medical Association.

Mr. Speaker, it is my pleasure and honor to place in nomination the name of Dr. Sam J. McClendon of San Diego. (Applause.)

Vice-Speaker Alesen: Dr. Sam J. McClendon has been nominated as President-Elect.

Dr. Harry J. Templeton (Alameda County): I would like to second the nomination.

Vice-Speaker Alesen: Are there further nominations? If the Chair hears none, the nominations will be close. Hearing none, the nominations are closed. How do you vote?

. . . Cries of "by acclamation." . . .

Vice-Speaker Alesen: All of those in favor of selecting Dr. Sam J. McClendon as President-elect signify by saying "aye," opposed "no."

. . . The motion was put to a vote and it was unanimously carried. . . .

Vice-Speaker Alesen: It is carried unanimously and Dr. Sam J. McClendon is elected.

Dr. Samuel Ayres, Jr. (Los Angeles): Mr Speaker and Members of the House of Delegates: The man whose name I want to place in nomination as the *Speaker of the House of Delegates* is very well known to all of us. He is a man who ranks at the top of his profession. He is a man who has his feet on the ground and he also has vision. If at any time we ever needed vision, it is right now. I have known this man personally for a great many years. I think everybody knows him.

I am not going to spend any more of the Association's time this afternoon but I want to name Dr. E. Vincent Askey to succeed himself.

Vice-Speaker Alesen: Dr. Askey has been nominated to succeed himself. Are there any other nominations?

Hearing no more nominations, the Chair declares the nominations closed.

All of those in favor of Dr. Askey as Speaker for the ensuing year signify by saying "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimously carried. . . .

Vice-Speaker Alesen: It is so ordered.

. . . The Speaker of the House, Dr. Askey, assumed the Chair. . . .

Speaker Askey: Nominations are in order for *Vice-Speaker.*

Dr. Carl L. Mulfinger (Los Angeles): Mr. Chairman and Members of the House of Delegates: I know of no one better qualified to assume the assistant Speakership of this House than the present encumbent, Dr. L. A. Alesen. I so nominate him.

Speaker Askey: Are there further nominations for the office of Vice-Speaker of this House? If I hear no further nominations, they will be declared closed. I hear no further nominations. They are declared closed. Dr. L. A. Alesen has been nominated as Vice-Speaker. All in favor of his election say "aye," opposed "no."

. . . The election of the Vice-Speaker was put to a vote. . . .

Speaker Askey: He is elected your Vice-Speaker. (Applause.)

The next is the election of the *District Councilors.* I want to call your attention to the requirements of our By-Laws and Constitution in regard to District Councilors. I am sure you all know them but for reason of legality, I wish to call your attention to them again. That is this: Each district shall in writing present to the Association Secretary the name of one or more nominees from their district. If there is more than one nominee, the House shall then elect one of the men so nominated, or if they do not wish to elect either one they may turn it down, in which case the delegation from that county may then present further nominations. If there are no nominations from the area the House, as a whole, may elect one from the floor.

The first vacancy is that of the Second District. You will be voting whether you sustain the nominations of the District. If there is only one you will vote to sustain it, or if there is more than one you will vote on the names submitted. In the Second District, the term of Donald Cass is expiring.

Mr. Secretary, do you have any nominations in your hands?

Secretary Kress: Mr. Speaker, the Second District has nominated Dr. Jay J. Crane for the office of *Councilor for the Second District (Los Angeles County).*

Speaker Askey: Is that the only nomination?

Secretary Kress: No other nominations for the Second District has been submitted.

Speaker Askey: The name of Jay J. Crane of Los

Angeles is presented to you. Is there a motion to sustain the nomination of Los Angeles County?

. . . It was moved, seconded, and put to a vote that the nomination be sustained. The motion was unanimously carried. . . .

SPEAKER ASKEY: Dr. Crane is elected being sustained by the House of Delegates as the nominee of Los Angeles County, the Second District.

The next District Councilorship vacancy is that of Fifth District, the term of Dr. R. Stanley Kneeshaw of San Jose expiring.

SECRETARY KRESS: The Fifth District delegates have met and have unanimously voted to recommend that Dr. R. Stanley Kneeshaw of the Fifth District succeed himself.

SPEAKER ASKEY: Are there any further nominations?

SECRETARY KRESS: No further nominations.

SPEAKER ASKEY: You have before you Dr. Kneeshaw. Is there a motion to sustain the election of Dr. Kneeshaw?

. . . It was so moved and seconded; the motion was put to a vote and unanimously carried. . . .

SPEAKER ASKEY: The nomination is sustained and he is elected.

Next is the vacancy in the Eighth Councilor District, the term of Dr. Frank A. MacDonald of Sacramento, expiring.

SECRETARY KRESS: Mr. Speaker, the delegates from the Eighth District have nominated Dr. Frank A. MacDonald of Sacramento to succeed himself as Councilor of the Eighth District. There are no other nominations.

SPEAKER ASKEY: You have heard the nomination which is before you of Dr. Frank A. MacDonald. Is there a motion to sustain the election?

. . . It was so moved and seconded; the motion was put to a vote and unanimously carried. . . .

SPEAKER ASKEY: It is carried; he is sustained and elected.

The next is the vote on the *Councilors-at-Large*. Since the Councilors-at-Large represent the society as a whole and not any one district, nominations are now open from the floor.

The first is for the term of Sam J. McClendon, term expiring. Dr. McClendon!

DR. MCCLENDON: I would like to place in nomination one of our very outstanding physicians from San Bernardino County, Dr. Walter S. Cherry.

SPEAKER ASKEY: Dr. Walter S. Cherry has been nominated for the term of Dr. Sam McClendon, term expiring. Are there further nominations for the office of Councilor-at-Large? If I hear no further nominations, they will be closed. I hear none. The nominations are closed.

I will call for a vote on the nominatoin of Dr. Walter Cherry.

. . . A vote was taken on the nomination and it unanimously carried. . . .

SPEAKER ASKEY: Dr. Walter Cherry has been elected. Dr. Cherry, will you please stand so these men and ladies can see you.

The next office is that of Councilor-at-Large for the term of Edwin L. Bruck, term expiring. Dr. Cass!

DR. DONALD CASS (Los Angeles): I have served on the Council for the last five years and most of that with Ed. Bruck. I consider him one of the outstanding Councilors. He has been past-president of the San Francisco County Medical Association; president of the Family Club and very active and interested in civic affairs at San Francisco. He is a very popular doctor, very strong and energetic, and he is a fearless man. I think it would be a great loss to the Association if Dr. Bruck did not succeed himself. It is with a great deal of pleasure I nominate Ed Bruck to succeed himself as Councilor-at-Large.

SPEAKER ASKEY: The name of Ed Bruck has been placed in nomination to succeed himself.

DR. HARRY J. TEMPLETON (Alameda County): Alameda County would like to have the privilege of seconding the nomination of our friend from our suburb to the West, Dr. Bruck.

SPEAKER ASKEY: Are there further nominations for the office of Councilor-at-Large? If I hear no further nominations they will be closed. Nominations are closed.

All of those in favor of electing Dr. Ed Bruck will signify by saying "aye," opposed "no."

. . . A vote was taken on the nomination and it was carried unanimously. . . .

SPEAKER ASKEY: It is carried and he is elected.

Election of A.M.A. Delegates

The next election is that of *Delegates to the American Medical Association*. The Delegates are elected for two calendar years. At this session of the C.M.A. House of Delegates, terms of Delegates elected for the calendar years 1946-1947 will expire on December 31, 1947. Each of these delegates will be elected separately. They cannot be elected as a group. Each individual office requires a separate election.

The first position is that of Delegate to the American Medical Association to fill the term of Dwight L. Wilbur, of San Francisco, term expiring. Do I hear a nomination?

A MEMBER: I would like to nominate Dr. Robertson Ward to fill that position.

SPEAKER ASKEY: Are there further nominations?

If there are no further nominations, they will be closed. All those in favor of the election of Dr. Robertson Ward to fill the position of Delegate to the American Medical Association for the term of Dr. Dwight L. Wilbur, term expiring, say "aye," opposed "no."

. . . A vote was taken on the nomination and it was unanimous. . . .

SPEAKER ASKEY: He is elected.

The next is for the term of S. J. McClendon, term expiring. Are there any nominations for this position?

DR. JOHNSON (Orange County): It would be superfluous for me to add to Dr. Remmen's words regarding my candidate. You have already shown your confidence in him. I, therefore, nominate Dr. McClendon of San Diego to succeed himself.

SPEAKER ASKEY: You have heard the nomination of Dr. McClendon. Are there further nominations? If not, the nominations are closed. All in favor of the election of Dr. Sam McClendon to succeed himself say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

SPEAKER ASKEY: He is elected.

The next office to be filled is that for the term of Dr. Lowell S. Goin expiring. Are there any nominations?

DR. CASS: I would like to nominate Dr. Goin to succeed himself.

SPEAKER ASKEY: Are there further nominations? If there are no further nominations, the nominations are closed. All in favor of the election of Dr. Lowell S. Goin as a Delegate to the A.M.A., say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

SPEAKER ASKEY: He is elected.

The next is the term of Dwight H. Murray of Napa,

term expiring. Are there nominations for this position?

Dr. Cline: I would like to nominate Dr. Murray to succeed himself.

Speaker Askey: The nomination is before you. Are there further nominations? There being no further nominatoins, I hereby declare the nominations closed. All of those in favor of Dr. Dwight H. Murray for the term expiring, to succeed himself, say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

Speaker Aksey: It is carried.

We next come to the election of the *Alternates to the American Medical Association.* The first one is for the term of Anthony B. Diepenbrock of San Francisco. He is an alternate to the first delegate who was elected, namely, to Dr. Ward.

A Member: I wish to nominate Dr. Diepenbrock to succeed himself.

Speaker Askey: Dr. Diepenbrock is nominated. Are there any further nominations. If not, they are declared closed. All those in favor of Dr. Diepenbrock's election will say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

Speaker Askey: The next is the term of Dr. Bon O. Adams, term expiring. Are there any nominations for this position?

A Member: I wish to nominate Dr. Bon O. Adams.

Speaker Askey: Bon O. Adams has been nominated. Are there further nominations?

There being no further nominations, the nominations are closed. All of those in favor of the election of Dr. Bon O. Adams say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

The next is for the term expiring of Leo J. Madsen. Are there any nominations to fill this position?

Dr. Remmen: I would like to place in nomination Dr. Regan who was the unanimous choice of the Southern Delegation.

Speaker Askey: Dr. Louis J. Regan has been nominated. Are there further nominations? If not, the nominations are closed. All those in favor of the election of Dr. Louis J. Regan say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

Speaker Askey: Dr. Regan is elected.

The next is for the term of Dr. John W. Green of Vallejo.

Dr. Kneeshaw: I would like to nominate the other half of that combination of Murray-Green. I do not see how one can go without the other. I would like to nominate Dr. John W. Green.

Speaker Askey: Dr. John W. Green has been nominated. Are there further nominations? If not, the nominations are closed. All of those in favor of the election of Dr. John W. Green to succeed himself, say "aye," opposed "no."

. . . The nomination was put to a vote and it was unanimous. . . .

Appointments to Fill Committee Vacancies

Speaker Askey: At this time we will have the announcement by the Secretary of the Council's nominations on members for the standing committees for approval by the House of Delegates.

Secretary Kress: Mr. Speaker and Members of the House: The new appointees recommended by the Council to fill vacancies on Standing Committees, to fill unexpired terms and terms ending in 1948 are indicated in the following roster:

Committee on Associated Societies and Technical Groups

John V. Barrow (Chairman)	Los Angeles	1946
Anthony B. Diepenbrock	San Francisco	1947
Edward F. Nippert	Hollywood	1948

Committee on Health and Public Instruction

J. C. Geiger (Chairman)	San Francisco	1946
E. Earl Moody	Los Angeles	1947
C. M. Burchfield	San Jose	1948

Committee on History and Obituaries

Hyman Miller	Los Angeles	1946
Morton R. Gibbons, Sr. (Chairman)	San Francisco	1947
Robert A. Peers	Colfax	1948
George H. Kress	ex officio	

Committee on Hospitals, Dispensaries and Clinics

Benjamin B. Black	Oakland	1946
Roy E. Thomas	Los Angeles	1947
Clarence E. Rees (Chairman)	San Diego	1948

Committee on Industrial Practice

Carl L. Hoag	San Francisco	1946
N. P. Dunne	Oakland	1947
Donald Cass (Chairman)	Los Angeles	1948

Committee on Medical Defense

Louis J. Regan	Los Angeles	1946
Nelson J. Howard (Chairman)	San Francisco	1947
William A. Key	San Mateo	1948

Committee on Medical Economics

Howard W. Bosworth	Los Angeles	1946
Wayne J. Pollock	Sacramento	1947
H. Gordon MacLean (Chairman)	Oakland	1948

Committee on Medical Education and Medical Institutions

William J. Kerr	San Francisco	1946
B. O. Raulston (Chairman)	Los Angeles	1947
L. R. Chandler	San Francisco	1948

Committee on Organization and Membership

L. H. Redelings	San Diego	1946
Carl L. Mulfinger (Chairman)	Los Angeles	1947
Harold G. Trimble	Oakland	1948

Committee on Postgraduate Activities

F. E. Clough (Chairman)	San Bernardino	1946
H. F. Freidell	Santa Barbara	1947
John C. Ruddock	San Diego	1948
George H. Kress	ex officio	

Committee on Publications

George W. Walker (Chairman)	Fresno	1946
F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
Secretary-Editor, ex officio		

Committee on Public Policy and Legislation

Edmund T. Remmen	Glendale	1946
Dwight H. Murray (Chairman)	Napa	1947
Lloyd E. Kindall	Oakland	1948
Association President	ex officio	
Association President-Elect	ex officio	

Advisory Committee

Junius B. Harris (Chairman)	Sacramento
H. R. Madeley (Vice-Chairman)	Vallejo
Wilson Stegeman	Santa Rosa

Committee on Scientific Work

George H. Kress (Chairman)	ex officio	
Fletcher B. Taylor	Oakland	1946
J. Homer Woolsey	Woodland	1947
Howard F. West	Los Angeles	1948
Francis L. Chamberlin	(ex officio, Sec'y, Section on Medicine)	
Eugene J. Joergensen	(ex officio, Sec'y, Section on Surgery)	

* * *

Editorial Board

For the Editorial Board, to serve during the coming year, the following group of members:

Chairman of the Board:

Albert J. Scholl, Los Angeles

Executive Committee:

Lambert B. Coblentz, San Francisco
H. J. Templeton, Oakland
Albert J. Scholl, Los Angeles
George W. Walker, Fresno

Anesthesiology:

William B. Neff, San Francisco
Roscoe C. Olmsted, Pasadena

Dermatology and Syphilology:

William H. Goeckerman, Los Angeles
H. J. Templeton, Oakland

Eye, Ear, Nose and Throat:

Frederick C. Cordes, San Francisco
Lawrence K. Gundrum, Los Angeles
George W. Walker, Fresno

General Medicine:
Lambert B. Coblentz, San Francisco
L. Dale Huffman, Hollywood
Mast Wolfson, Monterey

General Surgery (including Orthopedics):
Frederic C. Bost, San Francisco
Fred D. Heegler, Napa
William P. Kroger, Los Angeles

Industrial Medicine and Surgery:
John D. Gillis, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
William S. Kiskadden, Los Angeles
George W. Pierce, San Francisco

Neuropsychiatry:
Olga Bridgman, San Francisco
John B. Doyle, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles

Pediatrics:
William W. Belford, San Diego
William C. Deamer, San Francisco

Pathology and Bacteriology:
Alvin G. Foord, Pasadena
R. J. Packard, San Diego

Radiology:
R. R. Newell, San Francisco
John W. Crossan, Los Angeles

Urology:
Frank Hinman, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

SPEAKER ASKEY: You have heard the nominations for unexpired terms and of members for 3 year terms on the Standing Committees. Is there a motion to approve this list of names read?

. . . It was so moved and seconded. . . .

SPEAKER ASKEY: Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is carried and they are approved.

Reports of Reference Committees

We come now to the Reports of our various Reference Committees. First, is the Report of Reference Committee No. 1, on the Reports of Officers and Standing Committees, Dr. Paul Quaintance, Chairman.

* * *

Report of Reference Committee No. 1

DR. PAUL A. QUAINTANCE (Chairman): Mr. Speaker and Members of the House of Delegates: Your Reference Committee No. 1, consisting of Dr. Paul A. Quaintance, Dr. Glenn Curtis and Dr. Roger W. Barnes, has considered the items referred to it and respectfully submit the following report:

Section 1. *The Report of the General Officers:* The President, the President-elect, the Past President, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates and the Chairman of the Council have been reviewed.

Unless someone wishes to discuss any of these reports, your Committee recommends that they be approved and filed.

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ASKEY: Dr. Quaintance, if you will allow me to suggest, I wish you would read your whole report first and then we will come back and move each section for adoption, and then the report as a whole, if you will, sir. I think it would give us a better idea of the whole report if we would do that.

DR. QUAINTANCE:

Section 2. *The Reports of the President of the "Trustees of the California Medical Association,"* the Auditing Committee, the Editor and the Legal Department have been reviewed. Your Committee recommends that these reports be approved and filed.

Section 3. *The Reports of the District Councilors and the Councilors-at-Large* have been considered. Your Committee especially commends those Councilors who have organized public education campaigns with respect to pending compulsory health insurance legislation and recommends that these reports be approved and filed.

Section 4. *The Reports of the Standing Committees* have been reviewed: Executive Committee; Committee on Health and Public Instruction; Committee on History and Obituaries; Committee on Hospitals, Dispensaries and Clinics; Committee on Industrial Practice; Committee on Medical Defense; Committee on Medical Economics; Committee on Organization and Membership; Committee on Publications; Committee on Public Policy and Legislation and Committee on Scientific Work.

Section 4a. Inasmuch as there is now no coördination between the *postgraduate activities of the Committee on Medical Education and Medical Institutions, and the Committee on Postgraduate Activities,* both of which sponsor postgraduate programs, your Committee recommends that the work of these two committees and of *any future committees which may be appointed* to deal with the same type of program, should be correlated to a greater extent. It is further recommended that these committees attempt to work in liaison with the postgraduate medical organizations or committees throughout the State, whether they be sponsored by the C.M.A. or independent groups.

Your Committee recommends the approval of the reports of these committees.

Sectoin 5. The *Reports of the Special Committees* have been reviewed: Committee on Maternity-Pediatric Plan of Federal Children's Bureau (E.M.I.C.); Committee on Physicians' Benevolence; Special Liaison Committee on Medical and Hospital Plans in California; Advisory Committee to the California Bureau of Vocational Rehabilitation; Liaison Representative to California Veterans' Committee. Your Committee recommends that the efforts to adjust present difficulties with the Children's Bureau of the United States Department of Labor with respect to the hanging of this E.M.I.C. program and the compensation of participating physicians in California be continued.

Your Committee recommends that the reports be approved and filed.

Section 5a. The *Report of the Committee on the Industrial Fee Table* by Hartley F. Peart and the *Committee on Proposed Changes in the Industrial Accident Commission Fee Schedule* by Dr. Nelson J. Howard, have been considered jointly. Your Committee affirms the stand taken by Dr. Howard in his conversations with representatives of the Workmen's Compensation Insurance companies that the physicians of California would not accept a flat fee industrial accident schedule. Your Committee believes that the 15 per cent surcharge ordered by the Industrial Accident Commission is inadequate.

It is recommended that efforts be continued to obtain revisions of the Industrial Accident Fee Schedule to meet present day standards.

Your Committee recommends that these reports be approved and filed.

Section 5b. The *Report of the Committee on Participation of the Medical Profession in the War Effort; Procurement and Assignment Service* has been reviewed. Your Committee also recommends that a special location and re-location committee be created to cope with the remaining problems of distribution of physicians at the present time and following the present war emergency.

Section 5c. The *Report of the Committee on Postwar Plans of Medical Service and Social Security* has been reviewed. Your Committee recommends that active work within the scope of this Committee be carried on throughout the coming year.

Section 5d. The *Report of the Liaison Group to A.M.A. Council on Medical Service and Public Relations* has been reviewed. Your Committee commends Dr. Murray for his untiring and efficient service which he has given to the United Public Health League and for the assistance and stimuli the League has given to the A.M.A. Council on Medical Service and Public Relations.

Mr. Chairman, your Committee recommends the approval of these reports.

I move the adoption of the report.

SPEAKER ASKEY: You have heard the motion of the Chairman of this Committee that the report as a whole be adopted. If there is any desire to take it up, section by section, it will be granted but is there a second to adopt the report as a whole?

. . . The motion was variously seconded. . . .

SPEAKER ASKEY: Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: Thank you, Dr. Quaintance.

* * *

Report of Reference Committee No. 2

Next is the Report of Reference Committee No. 2 on Report of the Council, Report of the Secretary-Treasurer, and the Executive Secretary.

Dr. A. E. Moore!

* * *

DR. A. E. MOORE (Chairman): Mr. Speaker: Your Committee has met and considered its assigned material and would like to render the following report

Item 1: Report of the Council.

The Committee recommends the approval of the Report of the Council as printed. Special attention is called to the section on the United Public Health League. It is recommended that the House of Delegates go on record as approving the action of the Council in the continued further support of this activity.

I move the adoption of the Report of the Council as presented.

. . . The motion was seconded, and, there being no discussion, it was put to a vote and carried. . ..

SPEAKER ASKEY: The motion is carried and this section of the report is adopted.

DR. MOORE: Under item 1, Report of the Council, Section b, your Committee has considered the *Supplementary Report of the Council regarding the American Cancer Society* which has been presented in the form of a resolution. We recommend the deletion of paragraph five of this resolution as submitted which reads as follows:

"5. These tumor clinics make no charge for services and the members are not paid. The only cost of the patient is a small fee (usually about fifty cents) to cover stenographic and record expense.

"In view of the foregoing, it is the opinion of the California Medical Association that the establishment of so-called cancer prevention clinics is unnecessary; and, it is, therefore,

"Resolved, That the California Medical Association therefore declines to endorse them."

The resolution as recommended now reads as follows:

Resolution Re: American Cancer Society

WHEREAS, The American Cancer Society has requested the "approval and assistance" of the C.M.A. and its aid in having component county societies establish "Prevention Clinics," the C.M.A. makes the following statement:

The California Medical Association is aware of the constant increase in the ravages of cancer and is deeply concerned with the prevention and cure of this disease. The Association heartily endorses all serious attempts directed toward early diagnosis and adequate treatment and directs attention to the following considerations:

1. Early and accurate diagnosis of cancer is essential if the disease is to be controlled.

2. Such diagnosis may require quite extensive facilities including microscopy and x-ray studies.

3. Tumor clinics sponsored by the American College of Surgeons are in existence all over California and these clinics have easy access to the special services required.

4. The C.M.A. urges any person who suspects that he may be suffering from cancer to seek out his private physician or such tumor clinics and to present himself for examination.

5. The prevention clinics of the American Cancer Society are still in a highly experimental stage and are not under the direct supervision of the American College of Surgeons.

Therefore, be it

Resolved, That the C.M.A. declines to endorse these prevention clinics at this time, and that the component county societies be so notified; and, be it

Further Resolved, That the plan of the American Cancer Society prevention clinics be referred to the Cancer Commission of the C.M.A. for further study and early report to the Council.

I move the adoption of this resolution.

SPEAKER ASKEY: You have heard the motion to adopt this section of the report which adopts this substitute resolution. Is there a second?

DR. BRUCK: I second the motion.

SPEAKER ASKEY: Is there discussion in regard to this?

. . . The question was called for, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: The motion is carried. This section of the report is adopted. Proceed.

* * *

DR. MOORE: *Item 2: Report of the Secretary-Treasurer.*

Your Committee has reviewed the Report of the Secretary-Treasurer including the report of the Certified Public Accountant and recommends its adoption with commendation on the favorable cash surplus, especially in view of the large expenditures during the past year in connection with public relations and legislation.

I move the adoption of this section.

DR. TOLLEFSON (Los Angeles): I second the motion.

SPEAKER ASKEY: Is there discussion in regard to the motion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: This section of the Report is adopted. Proceed, Mr. Chairman.

DR. MOORE: Item 3.

Your Committee has reviewed and considered the *Report of the Executive Secretary* including the supplementary report concerning malpractice insurance premiums.

The Committee recommends that all information obtained by the various county medical societies of the State during the past year be sought out and made available to the Council before final action is taken.

I move that this section be adopted.

SPEAKER ASKEY: There is a motion to adopt this section of the report. Is there a second?

DR. J. M. DE LOS REYES (Los Angeles): Second the motion.

SPEAKER ASKEY: Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: The motion is carried.

Do you move the adoption of the report as a whole?

DR. MOORE: I so move.

SPEAKER ASKEY: The Chairman moves the adoption of the report as a whole. Is there a second?

. . . The motion was seconded, put to a vote and unanimously carried. . . .

SPEAKER ASKEY: The report as a whole is adopted.

Thank you, Dr. Moore.

We come now to the Report of Reference Committee No. 3, Resolutions, Amendments to the Constitution and By-Laws, New and Miscellaneous Business. Dr. Chandler, Chairman!

* * *

Report of Reference Committee No. 3

DR. L. R. CHANDLER (Chairman): Mimeographed copies of the report have been passed around to you. I wish to call your attention to the fact that after they were typed by the efficient staff of the C.M.A. office, the Committee had a final meeting to review the report and made a change in the Committee's recommendation on Resolution No. 4 which I will read when we get to that section of the Report. I will read the amended recommendation which is not the same as the one on the mimeographed sheet.

Inasmuch as each of these resolutions is mimeographed in this report, as the original resolution was presented verbatim, I would appreciate it if I don't have to read the original resolution each time and unless so instructed by the Chair, I will not read it.

Mr. Speaker and Members of the House: The members of Reference Committee No. 3, Dr. Samuel Ayres and Dr. Templeton and myself, in considering all matters of business referred to it have consulted with many members of the House of Delegates and several members of the Council of the California Medical Association and submit the following report:

Constitutional Amendment No. 1

Re: Past-President to not be a member of Council.
(Printed in March C. and W. M., on page 123.)

You have it before you; it has been printed and held over for a year. Your Committee recommends that this amendment be adopted.

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER ASKEY: This will require a little different procedure in view of the fact that a motion for adoption of an Amendment to the Constitution must be put to a vote and it requires a two-thirds vote of all those voting. It does not mean all of those present but two-thirds of those voting in order for it to be adopted. It must be adopted as written and published.

. . . The motion was put to a vote and it was carried unanimously. . . .

SPEAKER ASKEY: There being no adverse votes, and two-thirds, the majority of those voting, voting for it, it is adopted. Proceed, Mr. Chairman.

DR. CHANDLER: Constitutional Amendment No. 2 as printed. It has to do with the authority of the Council to provide for *Retired Memberships.* The Committee recommends that this Amendment be adopted.

SPEAKER ASKEY: The vote before you is whether you wish to adopt this Amendment No. 2 as presented. It is the recommendation of your Committee that it be adopted. It requires a two-thirds vote of those voting in order to adopt it. (Printed in March, 1945, C and W. M., on page 123.)

All of those in favor of the adoption of this Amendment of the Constitution say "aye," opposed "no."

. . . It was put to a vote and it was carried. . . .

SPEAKER ASKEY: There being no adverse vote and two-thirds of those voting, it is adopted.

Will you proceed, Mr. Chairman, and then you may consider your sections from here on as you had started?

DR. CHANDLER: There was a resolution submitted as part of the Supplementary Report of the Council made yesterday, May 6th, to the House of Delegates. This resolution was withdrawn by the Council. No action was taken.

Resolution No. I.—Concerning Principle Involved in Medical Practice

For resolution, as introduced, see page 327.

Resolution No. 1 was introduced by Joseph F. Griggs of Los Angeles. It is printed in detail as submitted. The Committee is in accord with the principles contained in this resolution but is advised that similar principles already have been considered and adopted by the California Medical Association. Therefore, *your Committee recommends that this Resolution be not adopted.*

Mr. Chairman, I move the adoption of this portion of the report.

SPEAKER ASKEY: Is there a second to the motion?

. . . The motion was seconded. . . .

SPEAKER ASKEY: Is there discussion on the motion which is that this section of the report be adopted. You see, this resolution would be defeated in your accepting the recommendation which is that it be not adopted. Do you understand that?

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: This section of the report is adopted.

Resolution No. II.—Concerning Spokesmen for A.M.A.

For resolution, as introduced, see page 327.

DR. CHANDLER: Resolution No. 2 introduced by Dr. Edwin L. Bruck.

After thorough consideration and considerable advice, your Committee submits the *following amended resolution.* I will read it.

WHEREAS, The American Medical Association has created a Council on Public Relations, known as Council on Medical Service and Public Relations which council is charged with the responsibility of representing the American Medical Association to the public and governmental agencies of the United States; and

WHEREAS, The presentation of the official point of view of the American Medical Association by other councils, committees and individuals, leads but to confusion and to different and divergent views, with the effect of apparent disunity in the profession; and

WHEREAS, At this time the profession is in need of greater unity than ever before in its history; therefore, be it

Resolved, That the Council on Medical Service and Public Relations shall be the sole agency for presentation of the attitude of the American Medical Association relative to matters in which the organized profession should or must make representation to the public or to the government; and, be it

Further Resolved, That the California member of the Board of Trustees of the American Medical Association is requested to present this resolution to the Board of Trustees of the American Medical Association at its next regular meeting.

The Committee recommends the adoption of the amended resolution.

Mr. Chairman, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ASKEY: You have heard the motion. Is there discussion?

DR. GOIN: I think there is going to be a considerable amount of difficulty if we try to instruct the California representative to the Board of Trustees. There isn't any such. Dr. Peers is a Trustee but this House has no authority to instruct him to do anything whatever and, if anything at all can be achieved, I do not think it can be done that way.

I *move*, therefore, *to amend* by striking that last "Resolved" and substituting therefor the last two "Resolveds" of the original resolution.

DR. BRUCK: I second the motion.

SPEAKER ASKEY: You understand now that before you is the discussion of the amendment.

DR. CHANDLER: May I speak to the amendment?

SPEAKER ASKEY: Dr. Chandler!

DR. CHANDLER: You will note the Committee does not recommend that the California member of the Board of Trustees be instructed to do anything. He is requested to present it.

SPEAKER ASKEY: Is there further question in regard to that?

DR. BRUCK: The idea in proposing this resolution to the House of Delegates yesterday is the result of a lot of thought and a long time of thinking. In the first place, I think there is no question in anybody's mind what we are trying to get at. If there is, I would like to enlighten you just a little bit. There has been so much of out-of-turn talking and out-of-turn speaking and cracks at various things that go on from certain parties and certain officers of the A.M.A. and that has gotten the American Medical Association into disrepute with every governmental agency of the United States at the present time. To support my contention, I believe you should have read the report and have heard the report of Dr. Murray and the members of the United Public Health League and Mr. Ben Read. They have supported everything we have had to say previously.

Since our resolution of last year, although it was defeated numerically, it was agreed we have noticed that there has not been so much of this. It seems to me that the only way a woodpecker gets any place is to keep pecking at something.

SPEAKER ASKEY: Is there further discussion on the *motion which is to substitute the two paragraphs* of the original motion for the last pargaraph of the substitute resolution?

. . . The question was called for. . . .

SPEAKER ASKEY: The question is to the amendment. All in favor of the adoption of the amendment will say "aye," opposed "no." . . .

. . . The motion was put to a vote and it was carried. . .

SPEAKER ASKEY: In the Chair's opinion the amendment is carried.

Mr. Chairman, will you proceed?

DR. CHANDLER: *The amended resolution as it now stands to be voted upon* consists of the first "Resolved" in the original resolution and the last two "Resolveds" in the original resolution.

I move the adoption of this portion of the report.

SPEAKER ASKEY: The motion is before you. Is there further discussion? If not, the question is before you of the adoption of the resolution as amended.

. . . The motion was put to a vote and it was carried. . .

SPEAKER ASKEY: It is adopted. Will you proceed, sir?

Resolution No. III.—Concerning Full-Time Employees of A.M.A.

For resolution, as introduced, see page 328.

DR. CHANDLER: Resolution No. 3 was introduced by Edwin L. Bruck of San Francisco. The resolution as originally presented is printed and is before you.

After securing considerable advice and canvassing the opinion of several delegates, the numbers of the Reference Committee believe it highly improbable to secure favorable action on this resolution by the American Medical Association and therefore *recommend that it be not adopted.*

I move the adoption of this portion of the report.

SPEAKER ASKEY: You have heard the motion. Is there a second?

DR. C. G. TOLAND (Los Angeles): I second the motion.

SPEAKER ASKEY: Is there any discussion on the motion which is to adopt this section of the report which recommends that Resolution No. 3 be not adopted.

DR. CLINE: I would like to *amend the motion* to place again before the House the original resolution as introduced by Dr. Bruck.

SPEAKER ASKEY: Dr. Cline, the action before the House would be to defeat the recommendation of the Chairman which leaves the original resolution before the House.

DR. CLINE: In order to make it clear, I would amend the motion of the Chairman of the Reference Committee to the effect that the report include the original resolution of Dr. Bruck.

SPEAKER ASKEY: In other words, the Chair believes that what Dr. Cline means by that is that he wishes *the original resolution to stand and become a matter of record.* Is that correct, Dr. Cline?

DR. CLINE: That is the intent.

SPEAKER ASKEY: Is there further discussion? Dr. Templeton!

DR. TEMPLETON: I speak as a member of Reference Committee No. 3. Dr. Peers, our Trustee of the American Medical Association, appeared before this Committee and strongly recommended that we not send this to the American Medical Association in its original form. He said that the California delegation had taken a terrific beating last year on motions that meant somewhat the same thing; at least, they had somewhat of the general spirit back of it, and he felt that we had no chance, and not the chance of the proverbial snowball, of putting this through. He asked that it not be sent to Chicago. I have a great deal of respect for his judgment.

SPEAKER ASKEY: To clarify the whole situation, the Speaker will rephrase Dr. Cline's amendment which is this: If you strike out the words "not adopted" in the report it will read that it be adopted. You see, the only change the amendment makes is to strike out the word "not" in the Committee's report. Is that satisfactory to the maker of the amendment?

DR. BRUCK: If that amendment carries, then it means that still the members of the Reference Committee believe it highly improbable to secure favorable action on this resolution by the American Medical Association, and, therefore, recommend that it be adopted. That does not make sense.

DR. PEERS: Mr. Speaker and Members of the House: I was very sorry when my friend, Ed Bruck, brought in that resolution. I went up before the Committee last night and told them I wanted to speak to them in regard to this resolution. I will have to use names. The Chairman of the Committee said, "Bob, you are not here to defend Fishbein, are you?" I said, "I am not here to defend any individual; I am here to defend the California Medical Association." I said that because I think if we pass this resolution and dig it up before the American Medical Association House of Delegates we are just going to get another good swift kick like we did last

year. I would hate to see that happen. We certainly lost a lot of prestige because of what happened last year. When I say that, I do not mean to criticize the men who brought in the resolution last year. I know everyone is an honest gentleman and everyone thought he was doing the best thing for organized medicine but I think it was a mistake. I think it would be a mistake for this House of Delegates to do tnis this year. We were working hard. I am going to work hard to get the California delegation back in the respect of the members of the House of Delegates of the American Medical Association. I think this would be a very bad thing. Everybody knows what it is. They are attacking a single person.

If you want to change things; if you want to get rid of this particular person, then you should change the personnel of the Board of Trustees of the American Medical Association. That can be done. That can be done, all right, if it is the demand of the medical profession of the United States. As I say, I was sorry Dr. Bruck brought it in. I have great respect for him. I know he is an honest gentleman. I think he thinks he is doing the very best thing for organized medicine but I think, Ed, you are making a mistake.

Dr. Cass: May I say something? As a member of the American Medical Association House of Delegates from California, I will state that we had a caucus of our delegates Saturday noon. Two of the members were not there but they were very much in the minority. The feeling of the group of delegates who are going to represent you at the American Medical Association is that if we go back there and repudiate and crawl along on our hands and knees: "We are sorry, Dr. Fishbein, for what we did last year"; we have lost a lot of face, but if we still believe in the action we took last year, we may go back there and get another kick in the pants but the reverberations of the slugging we gave Fishbein have not died down yet or at all. I think Dr. Murray's meeting with the National Health League did a great deal toward making Fishbein pull in his horns.

Although this resolution infers to us that we mean Fishbein, it doesn't mention him by name. It says "all of our full-time help, all of the full-time employees of the American Medical Association shall confine their activities to American Medical Association business," and it means they shall not go outside getting money for what they do on the outside. That will take in a lot of territory.

There are a lot of other employees of the American Medical Association but to those who know what we mean and whom we mean, it will show we still stand by our convictions and we would like to see Dr. Bruck's resolution passed in its original form. That is Resolution No. 3. I still believe that, although Dr. Peers disagrees, our delegation is strong. Men like Cline, Bruck, Murray and the rest of them are not afraid to speak their piece. Askey and Goin are not weak sisters and a kick in the pants wouldn't hurt them a bit. They are used to it.

I urge we pass this resolution and permit the California delegation to go back and continue their attack on what we think is wrong back there.

Speaker Askey: Dr. Gilman!

Dr. Gilman: Mr. Speaker: Possibly to expedite the matter, the thought has occurred to me that we might *lay this on the table* and, if that motion passes, I have another motion to make. I so move.

Speaker Askey: Is there a second to the motion to table that section of the report?

Dr. Ruddick: I will second the motion.

Speaker Askey: This is a motion to table and it is not debatable. This is a motion to table the last paragraph on that page, reading:

"After securing considerable advice and canvassing the opinion of several delegates, the members of the Reference Committee believe it highly improbable to secure favorable action on this resolution by the American Medical Assocaition and therefore recommend it be not adopted."

Dr. Remmen: Is it proper to table part of a resolution?

Speaker Askey: You are certainly able to table it, yes.

Is there a further point of order? No discussion is allowed.

All those in favor of tabling that part of the Committee's report will say "aye," opposed "no." . . .

. . . The motion was put to a vote and it carried. . . .

Speaker Askey: The motion is tabled.

Do you wish the floor, Dr. Gilman?

Dr. Gilman: I would now like to *move the adoption of Resolution No. 3, introduced by Edwin L. Bruck, M.D.*, San Francisco.

. . . The motion was seconded. . . .

Speaker Askey: Is there discussion on the motion? It is debatable

Dr. A. E. Blondin (San Diego): I would like to apply a little experience within our own California Medical Association to the problem within the American Medical Association. The San Diego delegation came to Los Angeles two years ago and received a terrible beating and a terrible series of kicks in the pants. I do not believe our delegation to the American Medical Association received any more of a beating than we took, however, during the next year circumstances came about so that we came back next year and we were received with open arms and have not been beaten since. As a matter of fact, one of our men has been honored by being elected your President this year. I think we made friends and, incidentally, during the next year we secured our point. I would like to support what Dr. Cass has said. I think the beating that the California delegation took at the Amercian Medical Association last year has done good and has made friends for us. I believe if we go back in the same way stating the same problems we might get somewhere and maybe circumstances have come back during the year so that we will not get such a beating as we took last time.

I would like to see this motion adopted.

Speaker Askey: Is there further discussion? Dr. Murray!

Dr. Dwight Murray: Mr. Speaker and Members of the House of Delegates: Since I was one who received part of the kicking last year, I think I ought to tell you how much it hurt. However, I soon forgot it.

I would like to report just briefly on a recent trip that Dr. Green and myself made to Portland at which time we had conference with two of the members of the Committee of the American Medical Association on Medical Service and Public Relations. It was the first time I had seen them since I received this kick in the pants and I said to them very jokingly, "I am surprised that you would even speak to me." Well, one of them said, "Come over here; I want to buy you a drink and I want to tell you how much we think of you. Don't think for a minute you disgraced yourself back there. I want to tell you that there was a certain individual by the name of Dr. Fishbein who never felt that anybody would have the temerity to introduce such a resolution before the House of the American Medical Association."

Since that resolution was introduced and since it was a fact that he was very much worried and alarmed about the whole situation, his attitude has definitely changed. I quite agree with what Dr. Bruck has said about the woodpecker—that he gets no place probably except by

keeping on pecking. I hate to disagree with Dr. Peers. He was a member of our delegation last year. He voted with our delegation and he supported us all he could. We appreciate that. We are glad we have a man from California who is a member of our Board of Trustees but I think if we will keep on we will have the same effect, perhaps, on the Board of Trustees as we had upon the Council on Medical Service and Public Relations, of getting them to establish a Washington office. Thank you.

SPEAKER ASKEY: Is there further discussion on the question?

DR. JOHN HUNT SHEPARD (Santa Clara County): Mr. Chairman and Members of the House of Delegates: In the past I have had the honor of representing this society as a member of their delegation to the A.M.A. on five different occasions during which time there was a most hectic meeting back there. One of the special meetings was called for considering the question of some of this legislation. Many of the members of the Board of Trustees of the American Medical Association throughout the United States were, at that time, personal friends of mine I hope I can say that they are today.

A few years ago when various articles were appearing in various newspapers entitled, "Your Health," I took it upon myself to clip a number of those articles from the papers. I put them in a little folder and presented them to the Council of the American Medical Association. That was the beginning of the fight of the C.M.A. against some of the actions and conduct of the members of the A.M.A. I am personally acquainted and have been for years with Morris and with many persons connected with the Association. I know that there is only one way to straighten out what many of us consider a mess in the A.M.A. and that is not to pull our guns.

I do not think there was ever any delegation to the A.M.A. that received more panning than the delegation to which I belonged when we met in Atlantic City. If there ever were two delegates that got panned right it was Ed Pallette and myself and that panning continued for some little time.

I am whole-heartedly in support of this resolution of Ed Bruck's. I want to congratulate him on the manner in which it is worded. I hope the Association will send our delegation back there instructed to fight to the end and, if they are beaten, they will take it as happily as Ed Pallette and I took it. Thank you.

SPEAKER ASKEY: Is there further discussion on the motion?

. . . The question was called for. . . .

SPEAKER ASKEY: All of those in *favor of the motion, which is to adopt Resolution No. 3 as originally introduced* by Dr. Edwin L. Bruck, say "aye" and those opposed "no."

. . . The motion was put to a vote and it was carried. . .

SPEAKER ASKEY: The motion is carried.

Mr. Chairman, will you proceed.

Resolution No. IV.—Concerning American Association of Physicians and Surgeons

For resolution, as introduced, see page 328.

DR. CHANDLER: Resolution No. 4 introduced by Delegates of the First District.

It is printed therein in full and your Committee submits the *following substitute resolution:*

Re: American Association of Physicians and Surgeons

Resolved, That consideration of the policies promulgated by the American Association of Physicians and Surgeons be referred to a special committee appointed by the Speaker of the House of Delegates for further study; this committee to consist of not less than nine members and to be thoroughly representative of the entire membership of the California Medical Association. This Committee shall be instructed to report its first findings to the Council wihtin 90 days and the Council shall make such recommendations to the House of Delegates as it considers proper.

This resolution is not contained in your mimeographed form.

Mr. Chariman, I move the adoption of this section of the report.

SPEAKER ASKEY: Is there a second?

. . . The motion was variously seconded. . . .

SPEAKER ASKEY: Is there discussion on the motion to adopt this section of the report which is the appointment of a special committee of nine members by the Speaker of the House to study and report to the Council within 90 days.

If there is no discussion, all of those in favor, will say "aye," opposed "no."

. . . The motion was put to a vote and it was carried. . .

SPEAKER ASKEY: It is adopted. Proceed.

Resolution No. V.—Advisory Planning Committee of the California Medical Association

For resolution, as introduced, see page 328.

DR. CHANDLER: Resolution No. 5 introduced by Dr. Regan would create an Advisory Committee of the California Medical Association. Your Committee, by a vote of two to one, Dr. Ayres dissenting, submit the *following substitute resolution:*

Be It Resolved, That the Council of the California Medical Association at all times shall make every possible use of all technical experts available to it, either directly or through its component county societies.

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ASKEY: You have heard the motion. Is there a second?

. . . The motion was variously seconded. . . .

SPEAKER ASKEY: Now it is open for discussion.

DR. AYRES: Mr. Speaker and Members fo the House: This resolution was presented by the Southern Delegation because we have felt that there is a distinct need for correlation in a study of some of the problems in economics and politics that we, as physicians, don't have time to go into. The only opposition which appeared to arise to the formation of the suggested committee of at least five members was the statement that, after all, the same men are functioning and, therefore, no committee is now needed. We, however, have felt, at least I have felt and others of the Southern Delegation have felt that this is not an adequate substitute for the formation of a definite committee. This Committee's purpose would be to be an Advisory Committee and it is not over anybody. They will not dictate to anybody. It will consist of men who are thoroughly qualified to interpret the public to the medical profession and to interpret the medical profession to the public.

It is true that the Council has selected an expert public relations man whose report you heard yesterday. I have no doubt that choice was a wise one and that this expert will be able to carry on an active campaign explaining to the public what we want but I can see of no possible harm in having this addition to this one man, a committee composed of five men such as, for instance, Mr. Ben Read, Mr. Hunton, Mr. Hassard and Mr. Cochems or Mr. Ebersole who have been for a long time familiar with these problems. This Committee would meet at regular intervals and discuss the various aspects of the problems. One man of that number, either Mr. Cochems or Mr. Ebersole, may be a public relations ex-

pert. Mr. Hassard may be a legal authority and so forth. It has various aspects and it seems to me it would be highly profitable for those men to meet together and consult with one another and then meet with the Council and present their findings before the Council. It would be perfectly possible to spend half a million or even a million dollars in an extensive campaign of advertising, billboards, newspapers and so forth and still not obtain the objective we want.

It was thought, for instance, putting all kinds of efforts behind a certain candidate for Governor would assure the medical profession we needn't have to worry about compulsory health insurance any more. Personally, I have always felt it a mistake to participate individually in political matters. I think this is a very appropriate time to find out who the likely candidates for Governor are going to be in both parties. Such things like that could very well be the concern of this Committee.

As I recall the statement made by our public relations man yesterday, there was no statement made of any effort to seek any kind of coöperation or understanding with any of the labor groups. That may seem a rather hopeless task at this stage of the game. I think it would be possible to approach not necessarily labor leaders but men who are recognized by the leaders of labor. I can cite several for you. There is in Los Angeles County a member of our Board of Supervisors. He has the respect of labor and I think it would be far better to bend a lot of our efforts toward influencing people of that sort and through them filter down to the labor movement.

There is no particular point, as far as I can see, in making this a class war. We are not fighting labor. We are not fighting lawyers. We are not fighting things. We are fighting for the things we believe right and proper.

Another argument why a committee such as this should be in existence is because it will be able to correlate all the little details, find out what the public is thinking in various aspects, and by doing this the Council will have this information for their consideration.

The Council can get rid of these men if they want to. This committee need not consist of these individuals I mentioned. It just seemed to me desirable.

I would favor the adoption of this resolution as originally presented.

SPEAKER ASKEY: Is there further discussion on the motion which is before you? Dr. Shephard!

DR. SHEPHARD: I, perhaps, should apologize by referring to past experiences which I had when I was a representative to the American Medical Association. There was a time when Dr. Mason was installed President while sick in bed when he was succeeded by Gordon Heyd of New York. At that meeting one day there was a group of us who were discussing some of our future plans for the A.M.A. I brought up the question of the way the medical profession of the state and of American was being run. You and I and the rest of us are all too busy practicing medicine to give due time and consideration to the various wide problems involved in the public relationship of the medical profession to the public.

You may also remember that in 1938 at the order of the Santa Clara County Medical Society I introduced a resolution before this House to raise our dues to $75.00 per year for the organization of a Public Relations Committee to spread the knowledge which we have for the welfare of the people. It was voted down and a small assessment of $10.00 per year was passed. There was only a small percentage of the men who did not pay that assessment.

I am most whole-heartedly in favor of this resolution of Dr. Ayres. It is a step forward. It is the second step which the Association has made in regard to straightening out some of our difficulties. The first step was made along that line when we had the fight to get an Executive Secretary. That came up before the Council of the California Medical Association for several years. I remember when I was a member of the Council. Dr. Shoemaker and I fought to do the same thing. We were voted down. We were passed over but we kept on fighting. Subsequently, the Council did see fit to put in an Executive Secretary, Mr. Hunton, and I believe all of us agree it was one of the best moves this Association ever made.

I think this resolution establishes this so-called Planning Committee to be composed of men of business, not of the profession, who can get the pulse of the public, who can see what they should do, and I think it is the most marvelous step forward.

Since we have just voted to raise our dues to $100.00, I am certain that the Council had in mind using a large percentage of that increase in dues to carry on the same ideals and plans which were embodied in the resolution which I had the honor of introducing in 1938 raising it to $75.00 per year per man.

I am most heartily in favor of this resolution. I trust that it will be heartily supported.

SPEAKER ASKEY: Is there further discussion on the motion that is before you? If not, the question will be put. For your clarification, the motion before you is to adopt the recommendation of the Committee which is the substitute resolution.

DR. REMMEN: I move that we take a recess in order to allow the Los Angeles delegation to caucus.

SPEAKER ASKEY: You do not need a motion for that. If you request it, it will be granted. For what period do you wish it?

DR. REMMEN: I would like about ten minutes.

Recess:

. . . A ten minute recess was had. . . .

SPEAKER ASKEY: The House is out of recess and is now constituted for business again.

At this time there is before you the motion to adopt the recommendation of the Committee which would be the adoption of the substitute resolution. Is there further discussion on this?

DR. JESSE L. CARR (San Francisco): Mr. Speaker:...

I want to speak to this Resolution No. 5. With the exception of one paragraph, I believe it is a splendid resolution. With this resolution we will not be either too late or with too little. I believe it would be a detriment to the resolution to name the individuals who are to serve. If we can amend that resolution and change that paragraph to the following—

SPEAKER ASKEY: Dr. Carr, the Chair will rule you out of order. We are speaking now to the motion which is to adopt the substitute resolution which, if adopted, will mean that this other matter will come up later. Dr. Carr is speaking now to Resolution No. 5. The motion before you is to adopt the substitute resolution. If it is adopted the whole thing would be out and the floor would be open to New Business. Is there further discussion on the motion before you?

. . . The question was called for. . . .

SPEAKER ASKEY: The question before you is on the motion to adopt the section of the Committee's Report with the *substitute resolution.*

. . . There being no further discussion, the motion was put to a vote and it was not carried. . . .

SPEAKER ASKEY: The motion is lost.

DR. REGAN: Mr. Speaker, I *move to amend Resolution No. 5* as printed in respect to paragraph 2 of the resolution to read:

3. That the Advisory Planning Committee of the California Medical Association shall consist of the Associate Legal Counsel, the Executive Secretary of the Alameda County Medical Association, the Executive Secretary of the Los Angeles County Medical Association, the Executive Secretary of the California Medical Association, the Executive Secretary of the Public Health League of California, the special representative of the Council of the California Medical Association, and such other lay employees of the California Medical Association or component societies as the Council may see fit to appoint.

SPEAKER ASKEY: There is a motion to adopt Resolution No. 5 with the amendment as stated. Is there a second?

DR. CARR: I second the motion.

SPEAKER ASKEY: It is now open for discussion.

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is adopted. The motion is now before you to adopt the resolution as amended

. . . The motion was put to a vote and it was unanimously carried. . . .

Resolution No. VI.—Concerning Christian Science Practitioners

For resolution, as introduced, see page 329.

DR. CHANDLER: Resolution No. 6, introduced by Dr. Carr. This resolution is before you. I will not read it. Your Committee recommends that this *resolution be not adopted.*

I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ASKEY: You have heard the motion. Is there any discussion? Dr. Carr!

DR. CARR: I realize as well as you do the fallacy of this resolution and it was not introduced with the presumption under any circumstances that Reference Committee No. 3 would move its adoption.

There are certain implications that you should be told about and it was with that idea in mind that I introduced the resolution. Dr. Delprat chided me on it. I promised to tell him a short story and I will make it short because the time is short. It has to do with Christian Science activities and particularly with our experience with them. Number 1, they die. So many people die and with the same diseases. They die unattended. It is their common practice, after they have died, to call a physician, one of us, to sign the death certificate because Christian Science Practitioners are unable to do so. In most cases today, the physician signs the death certificate which is not only unethical but it is illegal.

Point 2. After they die, particularly at the Health Home at San Francisco, they are held there until midnight because of political pressure. The Coroner's Wagon does not come within the grounds of the Health Home so the wagon is parked approximately three blocks from the Home and the two deputies and an investigator take the stretcher and carry it three blocks to the basement door which is locked; that is opened by the matron who pussy-foots up the back stairs, and there is a guard at each door on that floor, and there we get the body and take it out at the dead of night. We finally put the body in the ambulance after having carried it three blocks and then it is spirited away to the Coroner's office at approximately 1 A.M. I think that is funny.

Many of these people are dying from cancer, pneumonia and communicable diseases.

The medical value of such a resolution is, frankly and honestly, practically nil because not many of them have epidemic meningitis and not many of them have typhoid, although quite a few of them have diphtheria. The practical factor, however, is they are carrying communicable diseases and, without warning, they are allowed to walk the streets and no one knows what they have until it is too late. They are a public health hazard. This is not guesswork but it is real.

The third part of this is the political force that can be engendered by antagonizing these Christian Scientists. I have no compunction in saying that I think they are not valuable people to the commonwealth. I hope to see the day when there will be legislative action so that these Christian Scientists will not endanger our population. They are a detriment and they are a powerful force behind this compulsory health insurance. There is a possibility they may be included.

Finally, may I call your attention to this simple fact. They are the people who are sponsoring anti-vivisection. They are now engaged in collecting funds and circularizing the entire United States in the interest of the anti-vivisection movement.

That is my purpose in introducing this resolution. I realize that there are legal implications but they are not what you think because slander is only that which is said without truth. I have a list of some 150 cases in my pocket which run all the way from tuberculosis to a man who was dead four days and his wife thought he was getting better because his color was changing.

SPEAKER ASKEY: Is there further discussion on the motion of the Committee Chairman?

. . . There being no further discussion, the motion was put to a vote and it was carried. . . .

Resolution No. VII.—Concerning Chiropractors

For resolution, as introduced, see page 329.

DR. CHANDLER: Resolution No. 7, introduced by Dr. Carr of San Francisco. Your Committee recommends that the *resolution be laid on the table.*

I recommend the adoption of this part of the report.

SPEAKER ASKEY: Is there a second to the motion to table?

. . . The motion was seconded. . . .

SPEAKER ASKEY: The motion is not debatable.

. . . The motion was put to a vote and it was carried. . .

SPEAKER ASKEY: It is tabled.

Will you proceed, Dr. Chandler?

Resolution No. VIII.—Concerning California Physicians' Service

For resolution, as introduced, see page 329.

DR. CHANDLER: Resolution No. 8, introduced by Bryant R. Simpson of San Dieg.o This resolution was withdrawn by Doctor Simpson in view of action taken by the Council of the California Medical Association. The Committee is of the opinion that it would be of considerable value to the House of Delegates if a representative of the Council would explain its action. It is entirely up to the Council whether they care to do that or not.

SPEAKER ASKEY: If there is no objection, the resolution will be withdrawn. I hear no objection. It is withdrawn. Proceed, sir.

DR. CHANDLER: That isn't the question.

DR. GILMAN: Mr. Speaker and Members of the House of Delegates: At the time the resolution was withdrawn, the Chairman of the Council was very glad indeed to be requested to come before this House with a word of explanation.

The Seventh Council District presented a resolution to the Council of the California Medical Association which resolution was unanimously and immediately adopted. This resolution requires of the Council that they appoint a committee, a representative committee of the State of California, from members of the California Medical Association; two of the members of the Committee to be members of the Council. This Committee is

to study, and have the necessary funds made available to it to defray expenses of this study, the entire question of the prepayment of medical care in the State of California. It is also to study the California Physicians' Service. It is to report to meetings of the Council as decided by the Committee during the year and at the end of the year is to bring in recommendatoins to the House of Delegates regarding suggestions for the improvement of the pre-payment of medical care in the State of California as it applies to others and to other organizations and to the California Physicians' Service.

Are there any questions? I think I have made myself plain.

SPEAKER ASKEY: Are there any questions? (No response.)

DR. CHANDLER: I move the adoption of the entire report of Reference Committee No. 3 as amended.

SPEAKER ASKEY: Is there a second?

DR. BRUCK: I second the motion.

SPEAKER ASKEY: Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is carried.

* * *

DR. CHANDLER: I would like to thank the members of the Committee and all of the delegates and C.M.A. members who came up to the committee meeting last night and, particularly, these swell girls who did all the work on the papers. Thank you very much.

Recess for Second C.P.S. Meeting

SPEAKER ASKEY: At this time the Chair will declare a recess and ask you to change your hats and become members of the Administrative Body of California Physicians' Service. I will turn the meeting over to Dr. Glenn Myers, Vice-President of California Physicians' Service.

We are in recess.

. . . A recess was declared of the House of Delegates, to re-convene immediately after the meeting of California Physicians' Service Administrative Members. . . .

Post-Recess Meeting. C.M.A. House of Delegates

. . . The meeting of the C.M.A. House of Delegates reconvened at 3:45 P.M., on Monday, May 7, 1945.

SPEAKER ASKEY: The House of Delegates of the California Medical Association is hereby called out of recess and is out of recess and is now open again for business.

Under *Unfinished Business*, Mr. Secretary, is there any Unfinished Business remaining in your files?

SECRETARY KRESS: Mr. Speaker, there is no Unfinished Business or New Business.

SPEAKER ASKEY: Does any member of this House of Delegates have any business he wishes to bring before this House? Dr. Shepard!

DR. SHEPARD: When I listened to Dr. Goin's Presidential Address, I was very much impressed with it. I am asking permission to introduce a resolution regarding it at this time.

SPEAKER ASKEY: Dr. Shepard requests permission of the House to introduce a resolution in regard to Dr. Lowell Goin's Presidential Address of yesterday morning. He requests unanimous consent. If there is no objection to the introduction of this resolution, we will allow Dr. Shepard to introduce it. The Chair hears none; there is none and it will be introduced. Dr. Shepard!

DR. SHEPARD:

WHEREAS, The Address of our President was outstanding in its approach to the philosophies underlying our changing social order; be it

Resolved, That this House of Delegates recommend to the Council of the California Medical Association that they have this address printed in attractive form and a copy or copies sent to every public and county library in the State of California.

SPEAKER ASKEY: Is there a second?

SPEAKER ASKEY: You have heard the motion. Is there any discussion? If not, the question is before you. All those in favor of the motion say "aye," opposed "no."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is so ordered.

* * *

Is there further business that may appropriately come before us?

If not, we will proceed to the presentation of our officers.

Presentation of New Officers

SPEAKER ASKEY: Dr. Goin, will you present the new President?

DR. LOWELL S. GOIN: Mr. Speaker and Members of the House of Delegates: It is with a great deal of personal pleasure that I present to you our New President, Dr. Philip Gilman of San Francisco. (Rising applause.)

PRESIDENT GILMAN: Due to the lateness of the hour, I am going to say just a few words. A year ago, at the time you elected me your President-Elect, I tried to express the appreciation I felt on the honor extended me. At that time I felt very ordinary, when I considered the man whom I was to succeed. He has set such a very high standard that it is going to be next to impossible for any ordinary mortal to live up to that.

Now you have taken me on the other side and I am squeezed in between the Past-President and the next President-Elect. You have got me in a spot, however, in spite of that, I am going to do the best I can. If you give the whole-hearted support as evidenced by this meeting today of the House of Delegates throughout the ensuing year to your President, we will attempt, and I know, to reach at least fairly high toward the standards set by Dr. Goin. I thank you.

SPEAKER ASKEY: Your Speaker, very evidently, needs more tutoring in regard to "Speaker-ing." I am sure there was no insult intended that Dr. Goin was not introduced to you but I consider the rousing acceptance of the resolution and the motion previous to that gave him sufficient send-off. I apologize, Dr. Goin, for not having introduced you first.

At this time I will ask Dr. Philip Gilman to introduce to you the President-Elect.

DR. PHILIP GILMAN: Members of the House of Delegates I have known Sam McClendon for a good many years. We have agreed on many subjects, most subjects, but we have disagreed on many. We have, I feel that I am able to say, remained good friends.

It is with a great deal of pleasure that I present to you your President-Elect—a fine man.

DR. SAM J. MCCLENDON (President-Elect): Mr. Speaker, Fellow Officers of the California Medical Association, and Delegates and Friends: I come to you very humble today, appreciating the honor you have conferred upon me. I know the men who have preceded me and I know I will have a hard task in trying to follow in their footsteps and serve you people in the State of California. With your help and with the help of every member of the California Medical Association, I will try to do a good job. I will let action and deeds tell me what

to do, rather than come before you with a lot of promises.

I appreciate the honor and I will try to do my best to serve you.

SPEAKER ASKEY: Your Speaker needs no introduction after today and I need only say I appreciate from the depths of my heart your consideration and your kindness and your loyalty to me in what, I am sure you must know, is at times very difficult duties but ones which I will attempt to do in all fairness to every member of our Association. I will continue to do that in my next term.

At this time I wish to present to you your Vice-Speaker, Dr. Louis A. Alesen. Dr. Alesen, will you come forward, please?

VICE-SPEAKER ALESEN: Mr. Speaker, no speeches are in order. I am just the same old office boy doing the same old job.

SPEAKER ASKEY: At this time it is the pleasure of your Speaker to be able to present one of our Past-Presidents, one who saved my life by operating on me one night at one o'clock in the morning and whom I love very sincerely. It is my great pleasure to present to you Dr. Toland who will present the Retiring President's Certificate.

DR. TOLAND: Dr. Karl Schaupp, as you know, is the Past-President. He was supposed to have been here today to present this beautiful plaque. Formerly the Past-Presidents have received scrolls but the last three years the Presidents have received these plaques.

It is only the California Medical Association that presents it because they appreciate the work that Dr. Goin has done. We all admire him and respect him. He is a grand fellow, a great friend, and he is doing a lot for the medical profession in this State. He has done a lot and he will continue to do more.

I am certainly glad to know that he has received today another real office as Delegate to the American Medical Association.

Dr. Goin, it is my pleasure again to do something for you—to present this plaque.

DR. GOIN: Thank you, Dr. Toland.

I receive this plaque with a great deal of pride but also with a sort of strange mixture of sorrow and relief, relief because the burdens have been heavy and anyone would be glad to lay them down, and sorrow because it means that the association of myself from the official family of the Association with whom my relations have been most pleasant, every one of whom I admire greatly, is ended.

Thank you, all, for the many courtesies you have shown me. (Applause.)

MINUTES

SPEAKER ASKEY: At this time I would like to have a motion that the President, the Speaker and the Secretary of the Association be appointed as a committee to edit and approve the minutes of today. Do I hear such a motion?

. . . It was so moved and seconded. . . .

SPEAKER ASKEY: Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: The Committee is so appointed.

At this time I wish personally, as your Speaker, to thank the following members of your Committees:

The Chairman of the Credentials Committee, Dr. Paul D. Foster; Dr. Simpson and Dr. Carr;

Reference Committee No. 1: Dr. Paul Quaintance, Chairman; Dr. Curtis and Dr. Barnes;

Reference Committee No. 2: Dr. A. E. Moore, J. Frank Doughty and William Benbow Thompson;

Reference Committee No. 3 Dr. L. R. Chandler; Dr. Templeton and Dr. Ayres.

I think a rising vote of thanks for these committee members is in order. I will call for it.

I wish to call the attention of the Council to the fact that there will be a meeting of the Council immediately after this session in the adjoining Library. This is necessary for organization purposes. It will not take long but every member of the Council of the California Medical Association is asked to immediately come up there.

A motion for adjournment is now in order.

DR. GILMAN: May I have the floor for just a moment?

I cannot leave this meeting without calling for a vote of thanks to the Los Angeles County Medical Association and to their staff for the many courtesies and coöperation extended I so move.

SPEAKER ASKEY: All in favor say "aye," opposed "no."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: The Los Angeles County Medical Association is the recipient of our thanks.

A motion to adjourn is in order.

DR. GILMAN: I so move.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

SPEAKER ASKEY: It is ordered. We will adjourn.

. . . The meeting adjourned at 4:10 P.M. . . .

E. VINCENT ASKEY,
Speaker, C.M.A. House of Delegates.

GEORGE H. KRESS,
Secretary, C.M.A. House of Delegates.

OFFICIAL NOTICE

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-fourth (324th) Meeting of the Council of the California Medical Association*

The meeting was called to order in the Los Angeles County Medical Association Headquarters Building in Los Angeles, at 1:30 P.M., on Saturday, May 5, 1945.

1. **Roll Call:**

Present: Councilors Philip K. Gilman, Chairman; Lowell S. Goin, E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Sidney J. Shipman, Herbert A. Johnston, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Absent: Karl L. Schaupp.

Present by Invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; Mr. John Hunton, Executive Secretary; A. E. Larsen, Medical Director, California Physicians' Service; Hartley F. Peart, Esq., Legal Counsel; Howard Hassard, Esq., Associate Legal Counsel; Mr. Clem Whitaker, Public Relations Counsel; Malcolm Merrill, of the State Board of Public Health; T. Henshaw Kelly, C.P.S. Trustee; and Mr. William Bowman of C.P.S.

2. **Minutes:**

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (323rd) held in San Francisco,

* Reports referred to in the minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

February 25, 1945. (Printed in California and Western Medicine, for April, page 179.)

(b) Executive Committee Meeting (191st) held in San Francisco, April 8, 1945. (Printed in California and Western Medicine, for May, page 260.)

3. **Membership:**

(a) A report of the membership as of April 28, 1945, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1945: 7,606.

Total members in military service: 2,239.

(b) On motion made and seconded, it was voted to reinstate 330 members whose 1945 dues had been paid subsequent to April 1, 1945.

(c) On motion made and seconded, Retired Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Benjamin F. Walker, Fresno County
Charles Wesley Mattison, Los Angeles County
Frank L. Norton, Los Angeles County
Frank Lane Ready, Los Angeles County
Robert W. Wilcox, Los Angeles County
Charles W. Girdlestone, Riverside County
Samuel H. Keller, Riverside County
Fred Donnell West, Riverside County
Jesse W. Barnes, San Joaquin County
James B. Bullitt, Santa Clara County
Roland H. Prien, Santa Clara County
William Freeman Snow, Santa Clara County

4. **Financial:**

(a) A cash report as of April 28, 1945, was submitted.

(b) Report was made concerning income and expenditures for April and for four months, ended April 30, 1945.

(c) A balance sheet, as of April 30, 1945, was submitted.

On motion made and seconded, the above reports were received and placed on file.

5. **Interim Appointments:**

Council Chairman Gilman reported upon tentative appointments made since the last Council meeting held on February 25, 1945. On motion made and seconded, it was voted that the appointments which follow be confirmed:

(a) Philip K. Gilman, Donald G. Tollefson, and George H. Kress, appointed to a committee consisting of three members of the State Bar, three members of the State Department of Public Welfare and three members of the California Medical Association, to outline a study program relating to laws concerning the adoption of foundling infants and other children.

(b) Committee on Postwar Planning, as follows:

John W. Cline, San Francisco, California Medical Association

Philip K. Gilman, San Francisco, California Medical Association

Anthony B. Diepenbrock, San Francisco, State Board of Medical Examiners

Frank W. Otto, Los Angeles, State Board of Medical Examiners

L. R. Chandler, San Francisco, Stanford University School of Medicine

B. O. Raulston, Los Angeles, University of Southern California School of Medicine

Wilton L. Halverson, M.D., San Francisco and Los Angeles, State Board of Public Health

Phoebus Berman, Los Angeles, Los Angeles County Hospital

Benjamin W. Black, Oakland, Alameda County Hospital

Harold A. Fletcher, San Francisco, Procurement and Assignment Service

John Hunton (ex-officio), San Francisco, Secretary.

(c) Committee on Committees, to make report of vacancies on C.M.A. Standing and Special Committees and Editorial Board, as follows: Sidney J. Shipman, Chairman; Edward B. Dewey, and Frank A. MacDonald.

(d) The Council Chairman was authorized to appoint two members of the California Medical Association to be its representatives on a statewide Social Security Committee proposed by the California State Chamber of Commerce. H. Gordon MacLean of Oakland, and L. A. Alesen of Los Angeles, were appointed.

6. **Proposal to Establish a State Blood Bank in California:**

Upon invitation, Dr. Malcolm H. Merrill, Chief of the Division of Laboratories of the California State Department of Public Health, stated that during the past two years numerous requests had come to the State Department of Public Health to study the possibility of developing a coördinated statewide human blood and plasma program. Dr. Merrill said that eleven states have programs of varying types in operation at the present time. In his address, Dr. Merrill stated, "A study of well organized and operating blood and plasma banks both in California and elsewhere reveals that the basic requirement of human blood is approximately four units of 500 cc. each per general hospital bed per year Stated another way, this amounts to about 16 units per thousand population per year. Under optimal conditions there will be about 3 units of whole blood used for each unit of plasma."

Dr. Merrill informed the Council that "according to the studies carried on by the State Department, a program limited to plasma only is not the answer. It is less than 25 per cent of the answer." The suggestion had been made that California be divided into eight districts, each to have one or more permanent centers and satellite mobile bleeding centers. "The American Red Cross through its constituent local chapters would become the donor procurement agency. . . The basic costs for operating the program, which would approximate $5.00 per unit, would be met by the State appropriation assisted by local participation and local voluntary workers."

It was stated that Senate Bill 653, now before the California Legislature, would impose upon the State Department of Public Health responsibility for the development of a statewide program.

Mention was made that under date of April 6th, the San Francisco County Medical Society had adopted the following resolution:

"Resolved, That this Board request the Councilors from this district to oppose any inroads of the State Department of Public Health into the establishment or operation of blood banks in the State of California in any area where existing blood bank facilities are now adequate, and to oppose also the use of tax funds to defray the costs of processing and furnishing blood products for individuals who are able to pay the necessary charges for processing and furnishing such blood products."

A letter was also received from the Association of California Hospitals in which the statement was made that "S. B. 653 would not be the best type of legislation to promote statewide blood banks."

Discussion followed. On motion made by Councilor Goin, duly seconded, it was voted that the Council do not give approval to the proposed blood bank program, and for reasons such as were incorporated in the above resolution of the San Francisco County Medical Society.

7. **Proposed Assembly Bills 600 and 601 to Provide for Licensing of California Hospitals:**

Discussion was had concerning Assembly Bills 600 and

601 now pending in the California Legislature, which, if enacted, would provide that a bureau be established under the State Board of Public Health through which studies of California hospitals would be made so that these institutions could be maintained at proper standards and only approved hospitals licensed.

On motion by Councilor Dewey, duly seconded, it was voted to approve these bills.

8. Richmond Medical Center:

Concerning the subsidy granted by the California Medical Association to meet a deficiency in Doctors of Medicine in the Richmond shipbuilding center, a report thereon was made by Executive Secretary Hunton who stated that during the first year of operation, beginning May 1, 1944, the medical center at Richmond had incurred a deficit of slightly under $6,000.00, for which the C.M.A. was obligated under its original agreement to assume a cost up to $6,000.00 for the first three months of operation.

After discussion of the work that had been accomplished and the existing conditions in the Richmond Housing area, on motion by Councilor MacDonald, duly seconded, it was voted that the financial support by the California Medical Association to the Richmond Medical Center terminate on June 1, 1945.

9. Budget for Calendar Year 1946:

Concerning the budget prepared by the Auditing and C.M.A. Executive Committees for calendar year 1946, the Council voted to present the same to the House of Delegates. Under item 32, sub-items f and g, it was voted to change the budget allowance for supplies to $950 and the office postage allowance to $850.

10. American Cancer Society:

Concerning the "Prevention Clinics," which the American Cancer Society (former name of which was the American Society for the Control of Cancer), proposed to establish in California, a discussion of the implications involved led to a motion that a special committee consisting of Councilors Goin, Cline and McClendon be appointed to draft a resolution thereon.

The committee submitted a resolution and on motion made and seconded, it was voted to present the same to the C.M.A. House of Delegates for consideration. (The resolution as finally adopted appears in the minutes of the C.M.A. House of Delegates. See page 336.)

11. Place of Meeting of 1946 Annual Session:

Concerning place of meeting for the Annual Session in 1946, it was agreed that for the Duration, facilities for scientific meetings and sessions of the House of Delegates, away from hotels in order to conserve manpower, were available only in Los Angeles. It was voted that the Council recommend to the House of Delegates that Los Angeles be selected as the place of meeting for next year's (75th) Annual Session of the California Medical Association, it being understood that the Los Angeles County Medical Association would sponsor local meetings of the scientific sections.

12. Legal Department:

General Counsel Peart reported on A.B. 600 (Hospital Construction Act) and A.B. 601 (Hospital Licensing Act). The report was in line with a letter dated April 23, 1945, submitted by Mr. Peart to Council Chairman Gilman.

Mr. Peart also reported on property rights involved in x-ray films and made some suggestions which he agreed to submit to the central office for transmittal to interested persons.

13. California Physicians' Service:

Discussion was had concerning certain policies and needs of the California Physicians' Service. Comments were made by Council Chairman Gilman, Mr. William Bowman of C.P.S., Mr. Clem Whitaker, Dr. Dwight H. Murray, Dr. T. Henshaw Kelly and others.

Income ceiling clauses of beneficiary members the advantages and disadvantages of indemnity and fee-for-service procedures received consideration.

Dr. Kelly reported that the Board of Trustees of C.P.S. had given careful consideration to the 1944 resolution of the House of Delegates concerning an over-all manager and that the Trustees had voted that Mr. William Bowman who is familiar with the activities of C.P.S. should be promoted to the office of Executive Director and that Dr. A. E. Larsen would be made Medical Director.

Mr. Bowman discussed the C.P.S. need of an aggressive campaign along educational and other lines and it was voted that the sum of $2,000.00 monthly be paid to California Physicians' Service for a period of six months, in order to carry forward this needed work.

14. Annual Dues for 1946:

The Council took up the consideration of Association activities and needs and after full discussion, upon motion by Dr. Goin, duly seconded, the following resolution which had been drafted by Drs. Goin and Cline and Mr. Peart, was unanimously adopted:

With respect to the annual dues for next year, the Council in submitting its recommendation to the House, has been guided by the following circumstances:

(a) Loss of revenues in the past three years, due to waiver of dues of members in the Armed Services, now numbering over 2,200.

(b) Need for adequate funds to aid doctors returning from the Armed Services and, in general, to assist during the inevitable disruption of relocation from war to peacetime practice.

(c) Need for adequate funds for postgraduate studies, and refresher courses for doctors whose practices have been restricted, due to military service or work in war industrial areas.

(d) Need for further funds to promote more widespread participation in voluntary medical and hospital prepayment plans; and

(e) Necessity of reëstablishing the reserves of the Association, which are being constantly diminished by costly national and state public relations activities and increased cost of operation of all Association functions.

In view of the foregoing, the Council unanimously recommends that the annual dues for 1946 be fixed at one hundred ($100.00) dollars per member.

15. Indemnity Plans Proposed by the Alameda County Medical Association:

After discussion of the indemnity plans which had been submitted by members of the Alameda County Medical Association, it was voted that a special committee consisting of Drs. Dwight H. Murray, Sam J. McClendon, Frank A. MacDonald, and R. Stanley Kneeshaw, and Mr. Clem Whitaker be appointed to confer with Alameda County Delegates in the hope that an agreement might be reached concerning steps and procedures.

Upon motion by Councilor Goin, it was voted to approve the following resolution concerning California Physicians' Service:

WHEREAS, California Physicians' Service has always been and is now an earnest attempt to provide prepaid medical care for the largest possible number of people; and

WHEREAS, It is of the greatest importance that the generous and wholehearted support heretofore afforded California Physicians' Service by physicians of California continue; now therefore be it

Resolved, That the Council of the California Medical Association urges the House of Delegates to re-indorse

California Physicians' Service; and be it further

Resolved, That the Council of the California Medical Association advises and urges the House of Delegates to make no change in the present form of California Physicians' Service.

16. **Time and Place of Next Meeting:**

It was voted that the next meeting of the Council be held at the Town House in Los Angeles, on Sunday evening, May 6, 1945.

17. **Adjournment.**

PHILIP K. GILMAN, M.D., *Chairman*,
GEORGE H. KRESS, M.D., *Secretary*.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-fifth (325th) Meeting of the Council of the California Medical Association

An informal dinner meeting, tendered in honor of retiring President Lowell S. Goin, was held on Sunday, May 6, 1945, at 6:30 P.M., at the Town House in Los Angeles.

1. **Roll Call:**

Councilors Present: Philip K. Gilman, Chairman; Lowell S. Goin, E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Dewey R. Powel, Sam J. McClendon, Edward B. Dewey, Sidney J. Shipman, Herbert A. Johnston, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Councilors Absent: Karl L. Schaupp.

2. **Discussion of Prepayment Plans of Medical and Hospitalization Services:**

Discussion was had concerning prepayment medical and hospitalization plans and differences that had arisen in various portions of the State concerning procedures.

Council Chairman Gilman explained the steps that had been taken to bring about an adjustment and it was voted that the Council Chairman be instructed to formulate a plan and present the same at the meeting to be held on the following day.

3. **Adjournment:**

There being no further business, the meeting adjourned.

PHILIP K. GILMAN, M.D., *Chairman*.
GEORGE H. KRESS, M.D., *Secretary*.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-sixth (326th) Meeting of the Council of the California Medical Association

The meeting was called to order in Parlor B of the Elks Club, in Los Angeles, at 12:00 noon, on Monday, May 7, 1945.

1. **Roll Call:**

Councilors present: Philip K. Gilman, Chairman; Lowell S. Goin, John W. Cline, Lloyd E. Kindall, Harry E. Henderson, Edwin L. Bruck, R. Stanley Kneeshaw, Sidney J. Shipman, Dewey R. Powell, Edward B. Dewey, H. A. Johnston, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Councilors Absent: E. Vincent Askey, Karl L. Schaupp, Donald Cass, Axcel E. Anderson, Sam J. McClendon, and E. Earl Moody.

2. **Public Policy and Legislation:**

Council Chairman Gilman asked Doctor Dwight Murray, Chairman of the Committee on Public Policy and Legislation to present a matter that had been called to his attention.

Dr. Murray, referring to recent conferences with members of the California Legislature concerning public health legislation, felt it would be most advisable to have one or more members of the California Legislature address the Council at an early date.

It was agreed that Council Chairman Gilman and the Chairman of the Committee on Public Policy and Legislation, Dr. Dwight H. Murray, should extend an invitation or invitations in due course to Legislators whom they deemed it advisable to invite for such conference.

It was agreed that the necessary funds to cover the expense of such conferences be authorized.

3. **C.M.A. Committee to Meet With Representatives of 17 Mid-Western States:**

A letter was read from the Secretary of the Michigan State Medical Society relative to a recent conference held by representatives of some seventeen Mid-Western States. The conference had to do with a centralized plan of procedure whereby the regional and national interests of scientific and organized medicine would be promoted, through conjoint action of representatives of constituent medical associations and the American Medical Association.

After discussion, the Council Chairman was authorized to appoint a committee to represent the California Medical Association at a future conference, expenses of travel to be covered by the California Medical Association. The committee appointed is: Philip K. Gilman, M.D., Dwight H. Murray, M.D., Mr. Ben Read, Mr. Howard Hassard, and Mr. John Hunton.

4. **Assembly Bill 1344 (Scientific Blood Tests):**

Informal discussion took place concerning A.B. 1344, and it was voted to approve this bill.

5. **Special C.M.A. Committee to Study Prepayment Plans:**

Council Chairman Gilman reported concerning informal conferences held with members of the Alameda and San Diego County Medical Societies relative to resolutions which it had been proposed should be presented to the House of Delegates.

Council Chairman Gilman then stated an agreement had been reached that proposed resolutions would not be submitted at the present time, if a representative California committee would be appointed to study the work of California Physicians' Service and other prepayment medical and hospitalization plans and procedures, the committee so appointed to report at meetings of the Council and of the next House of Delegates. The committee appointed consists of the following: Harry E. Henderson, Sidney J. Shipman, Jay J. Crane, Samuel Ayres, Jr., Peter Bleng, John E. Young, Maurice Hopkins, A. E. Moore, L. R. Chandler, H. J. Templeton, A M. Meads.

6. **Allocation of Voting Units in the C.M.A. House of Delegates:**

Councilor Green brought up for informal comment the proposals concerning reallocation of voting units in the House of Delegates. It was felt that the subject was one that concerned the House of Delegates.

7. **Adjournment:**

There being no other business, the meeting was adjourned.

PHILIP K. GILMAN, *Chairman*,
GEORGE H. KRESS, *Secretary*.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-seventh (327th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Library of the

Los Angeles County Medical Association, Los Angeles, on Monday, May 7, 1945, subsequent to the adjournment of the House of Delegates.

1. **Roll Call:**

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Walter S. Cherry, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, and George H. Kress, Secretary.

2. **Organization Meeting:**

(a) Philip K. Gilman was nominated as Chairman and unanimously elected.

(b) John W. Cline was placed in nomination for office of Vice-Chairman and unanimously elected.

(c) Chairman Gilman announced as the Auditing Committee for the next fiscal year: John W. Cline, Chairman; Edwin L. Bruck; and Lloyd E. Kindall.

* * *

3. **Executive Session:**

The Council went into executive session, Dr. Gilman acting as Chairman and Secretary. Actions taken in executive session follow:

(a) The Association Secretary-Treasurer and Editor of California and Western Medicine, George H. Kress, M.D., was reappointed for the coming year, at his present salary of $8,740.

(b) Executive Secretary John Hunton was reappointed for the coming year, his salary being increased from $9,000 yearly, to $12,000 yearly.

(c) The firm of Peart, Baraty and Hassard was reappointed as General Counsel, the retainer of $4,000 yearly plus $600.00 for clerical aid being increased to retainer fee of $6,000 plus $900.00 for clerical aid.

(d) Allocation for Committee on Public Policy and Legislation to be determined by C.M.A. Executive Committee after consultation with Chairman Dwight H. Murray.

(e) The Council voted that Chairman Gilman write a letter on behalf of the C.M.A. Council to the legal firm of Peart, Baraty and Hassard, expressing the appreciation of the Council for the excellent service that had been rendered by them to the medical profession of California.

Philip K. Gilman, *Acting Secretary.*

* * *

4. **Recess for Executive Session Closed:**

Council then rose from Executive Session.

5. **Time and Place of Next Meeting:**

Upon motion duly made and seconded, it was voted that the time and place of the next Council meeting should be left to the decision of the Chairman.

6. **Adjournment:**

There being no further business, upon motion duly made and seconded, it was voted that the meeting adjourn.

Philip K. Gilman, M.D., *Chairman,*
George H. Kress, M.D., *Secretary.*

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Ninety-second (192nd) Meeting of the Executive Committee of the California Medical Association

The one hundred ninety-second (192nd) meeting of the C.M.A. Executive Committee was called to order in the Library of the Los Angeles County Medical Association on Monday, May 7, 1945, subsequent to adjournment of the meetings of the House of Delegates and Council, Chairman John W. Cline, presiding.

1. **Roll Call:**

Present: President and Council Chairman Philip K. Gilman; President-Elect Sam J. McClendon, Speaker E. Vincent Askey, John W. Cline, Chairman of the Auditing Committee, and Secretary-Treasurer George H. Kress.

2. **Election of Chairman:**

The Secretary stated this was the organization meeting of the Executive Committee. Upon motion duly made and seconded, it was voted that John W. Cline of San Francisco be elected Chairman.

3. **Adjournment:**

There being no other business, the meeting adjourned.

John W. Cline, *Chairman,*
George H. Kress, *Secretary.*

MEMBERS' ANNUAL MEETING OF "TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION"

Minutes of the Seventeenth (17th) Meeting of Members

Pursuant to call of the president and notice by the secretary duly and regularly given in accordance with the By-laws, the regular annual meeting of the members of the "Trustees of the California Medical Association," a California corporation, was held in the Library of the Los Anglees County Medical Association, Los Angeles, California, on Monday afternoon, May 7, 1945, following the annual organization meeting of the Council of the California Medical Association.

There were present: Philip K. Gilman, Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. Maconald, John W. Green, Walter S. Cherry, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, and George H. Kress.

A quorum present and acting.

Philip K. Gilman, First Vice-President of the corporation, acted as chairman of the meeting. George H. Kress, secretary of the corporation, acted as secretary of the meeting.

The minutes of the last meeting of Members of the "Trustees of the California Medical Association" having been sent to all members, upon motion duly made and seconded, it was voted that the same be approved and the actions taken therein, ratified.

The meeting then proceeded to the election of directors of the corporation to serve for the ensuing year, or until their successors shall be elected and qualified. Upon motion duly made, seconded and unanimously carried, the following were elected to serve as directors of the corporation for the ensuing year or until their successors shall be elected and qualified:

Philip K. Gilman, Sam J. McClendon, E. Vincent Askey, George H. Kress, Edwin L. Bruck, John W. Cline, and Lloyd E. Kindall.

There being no further business to come before the meeting, upon motion duly made, seconded, and unanimously carried, the meeting adjourned.

Philip K. Gilman, *1st Vice-President,*
George H. Kress, *Secretary.*

DIRECTORS' REGULAR MEETING OF "TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION"

Minutes of the Forty-first (41st) Meeting of the Board of Directors

Pursuant to the By-laws, a regular meeting of the Di-

rectors of the "Trustees of the California Medical Association," was held in the Library of the Los Angeles County Medical Association, in Los Angeles, California, on Monday afternoon, May 7, 1945, immediately following the meeting of the Members of the "Trustees of the California Medical Association."

Present were the following Directors: Philip K. Gilman, Sam J. McClendon, E. Vincent Askey, Lloyd E. Kindall, George H. Kress, Edwin L. Bruck, and John W. Cline.

Philip K. Gilman called the meeting to order and George H. Kress acted as Secretary.

The Chairman stated that the first order of business was the election of officers to hold office for one year and until their successors were elected or appointed.

On nominations duly made and seconded the ballots cast and taken, the following Directors were unanimously elected to the offices of the corporation set opposite the name of each thereon respectively:

Philip K. Gilman, President
Sam J. McClendon, First Vice-President
E. Vincent Askey, Second Vice-President
George H. Kress, Secretary
Edwin L. Bruck, Assistant Secretary
John W. Cline, Treasurer
Lloyd E. Kindall, Assistant Treasurer.

There being no further business, upon motion duly made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, *President,*
GEORGE H. KRESS, *Secretary.*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (25)

Alameda County (5)

Daggett, Earl H., *Oakland*
Gregory, Waldron A., *Oakland*
Haun, Theodore H., *San Lorenzo Villiage*
McWhirter, W. L., *Centerville*
Payne, Jeannette A., *Berkeley*

Los Angeles County (3)

Alpert, Clarence D., *Los Angeles*
Dale, Mary B., *Pasadena*
Shulman, Leon J., *Los Angeles*

Marin County (1)

Nass, Frederick C., *San Quentin*

Riverside County (1)

Walker, Arthur W., *Los Angeles*

San Bernardino County (1)

Miller, Fred C., *San Bernardino*

San Diego County (5)

Brownell, Emily B., *San Diego*
Friedberg, Irwin W., *La Mesa*
Goebel, Grace B., *San Diego*
Maurer, Esther L., *San Diego*
Murphy, Michael J., *San Diego*

San Francisco County (7)

DeBell, Grace, *San Francisco*
Goldwyne, Alfred Josef, *San Francisco*
Ruesch, Jurgen, *San Francisco*
Smith, Irma, *San Francisco*
Offield, Leonard D., *San Francisco*
Talbot, Grace McKellips, *San Francisco*
Turkel, Henry William, *San Francisco*

Solano County (1)

Nesting, Orlando S., *Vallejo*

Sonoma County (1)

Sturges, J. Hubert, *Santa Rosa*

Transfers (2)

Humphreys, Jasper M., from *Fresno* County to *Butte-Glenn County*
Lobel, Charles S., from *Los Angeles* County to *San Diego* County

Retired Members (12)

Barnes, Jesse W., *San Joaquin County*
Bullitt, James B., *Santa Clara County*
Girdlestone, Charles W., *Riverside County*
Keller, Samuel H., *Riverside County*
Mattison, Charles Wesley, *Los Angeles County*
Norton, Frank L., *Los Angeles County*
Prien, Roland H., *Santa Clara County*
Ready, Frank Lane, *Los Angeles County*
Snow, William Freeman, *Santa Clara County*
Walker, Benjamin F., *Fresno County*
West, Fred Donnell, *Riverside County*
Wilcox, Robert W., *Los Angeles County*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Cowan, Angus Bertram. Died at Fresno, April 20, 1945, age 74. Graduate of the Cooper Medical College, San Francisco, 1893. Licensed in California in 1894. Doctor Cowan was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Hench, John Madison. Died at Stockton, May 7, 1945, age 71. Graduate of the University of Illinois College of Medicine, Chicago, 1906. Licensed in California in 1914. Doctor Hench was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Koch, Pearl Elizabeth. Died at San Francisco, April 7, 1945, age 37. Graduate of the Washington University School of Medicine, St. Louis, Missouri, 1938. Licensed in California in 1941. Doctor Koch was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✠

Teaby, Walter Leon. Died at Monterey, May 2, 1945, age 74. Graduate of the College of Physicians and Surgeons of San Francisco, 1903. Licensed in California in 1904. Doctor Teaby was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

He who, grown aged in this world of woe,
In deeds, not years, piercing the depths of life,
So that no wonder waits him.

—Byron, *Childe Harold,* Canto iii, st. 5.

Think'st thou existence doth depend on time?
It doth; but actions are our epochs.

—Byron, *Manfred,* Act ii, sc. 1, l. 54.

CHAPTER VI

RE: COMPULSORY HEALTH INSURANCE BILL PENDING IN 1945 CALIFORNIA LEGISLATURE (56TH SESSION)

California and Western Medicine for January, 1945, on pages 1-4 and 25-40 presented informative comments and items dealing with proposed Sickness Insurance laws for California.

In the issue of February, on pages 51-53 and 64-92 the items were continued as Chapter II of the series.

In the March number of California and Western Medicine the sequence appeared as Chapter III, pages 123-126.

Chapter IV had place in the April number, on pages 188-198.

In the May number of California and Western Medicine the sequence was given as Chapter V. (Pages 276-289.)

In the present number of California and Western Medicine, the sequence is given as Chapter VI.

* * *

Indexes of Health Insurance Items

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March (Chapter III)	123	I-XXX
April (Chapter IV)	188	I-XX
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ITEM I

Warren Offers Alternative State Health Program

Sacramento, May 8.—Governor Warren came up with an alternative compulsory State health insurance proposal today, and then startled his evening press conference by waving an olive branch at legislative opponents of his health insurance program.

Warren's announcement came after a lengthy conference with groups favoring compulsory health insurance. These include the A.F.L. and C.I.O. union groups, the League of Women Voters and the Parent-Teacher Association.

These were the groups he invited about three weeks ago to discuss legislation that would represent the views of the groups generally in the place of bills now languishing in the Assembly Public Health Committee.

New Bills Coming Up

The Governor said that as a result of the conference two bills will be submitted. One will embody generally, "with no radical changes" the general principles set forth in the bills now in committee. Details are to be worked out in the drafting.

The second bill will provide only for hospitalization. This bill will be offered if the first one is refused passage. The costs would be financed by a payroll tax on employers and employees. But in the second instance it would be a smaller tax because the insurance coverage would not be so general.

Special Session Suggested

In response to questions the Governor then made an unexpected observation that if the Legislature appointed an interim committee to study the whole subject of State health insurance, and provided that it report back on a certain day, say within six months, and then request a special session, say next January, to consider and act, "it might have a salutary effect." His suggestion of a special session was considered by some a veiled offer.—Los Angeles *Times*, May 9.

ITEM II

A Fight Over State Funds

Health Bureau Officials Protest Assembly's Plan to Reduce Their Operating Budgets

Sacramento, May 12.—The State Motor Vehicle Department and the State Health Department today protested in the Assembly against cuts in their budgets. . . .

Dr. Wilton L. Halverson, State Health Director, argued against a $119,000 reduction in the Health Departments' allotment amid indications that the amount might be restored.

Their statements highlighted Assembly hearings on amendments to Governor Warren's record $683,000,000 budget. . . .—San Francisco *Chronicle*, May 13.

ITEM III

Two New Bills to Revive the Fight on Health Plans

Sacramento, May 13.—A fresh fight on public health and hospitalization insurance legislation was foreseen today as the Legislature prepared for the introduction tomorrow of two new bills on this controversial subject.

The measures are proposed by Governor Warren as a compromise and an alternative to the prepaid medical insurance bills sponsored separately by the administration and the C.I.O., and which ran into stonewall opposition in the Assembly Public Health Committee.

The compromise bill on an all-inclusive prepaid public health and hospitalization service includes a settlement of the differences between the labor groups and the administration, but in no wise meets the approval of the Califor-

nia Medical Association, which has vigorously opposed all such legislation.

This measure is intended to be pressed on the floor of the Assembly with the fullest vigor. If it fails of passage, then the alternative bill, which provides for hospitalization service only, will be pushed. . . .

Indicative of the trend toward adjournment were the meetings Saturday of both the Assembly and the Senate. . . .—San Francisco *Chronicle*, May 14.

ITEM IV

Compulsory Health Insurance Bill Before Assembly

Hospital Pay Measure to Be Linked With Warren Plan

Sacramento, May 14.—A new bill to set up a State insurance system to pay the hospital bills of most California residents was scheduled to be introduced in the State Assembly today.

Test votes were scheduled also in the Assembly which may indicate whether Governor Warren's 683-million-dollar State budget will be adopted without substantial changes.

A new compulsory health insurance bill was to be introduced along with the hospital care bill, according to Assemblyman Vincent Thomas (D., San Pedro), chief author of a health insurance measure backed by the California C.I.O. Council.

The bills will be backed both by the C.I.O. and by groups which have favored a health insurance bill sponsored by the Governor.

Mr. Thomas said that action will be sought on the hospital bill only if it appears that the health insurance bill cannot be passed.

The new health bill differs only technically from previous measures on the subject. Hospital and doctor's fees of employed persons and their families would be paid out of a fund made up of a 1½ per cent payroll tax cach on employers and employees.

The hospital insurance plan calls for a ½ per cent payroll tax on both workers and employers. Tax collection would start next January 1, and benefits would be paid after October 1, 1946. Any persons who earned $300 a year or more would have hospital bills paid for himself and his family for illnesses of not more than 30 days.

The system would be run by a commission of eight members, including the State director of public health, a physician or surgeon, a hospital administrator, two representatives each of employers and labor and one of agriculture. . . .—San Francisco *News*, May 14.

ITEM V

Assembly Gets Hospital Bill

Measure Provides Compulsory Pay Deductions for Care

Sacramento, May 15.—A prepaid hospital service act (A.B. 2201) to be financed through compulsory contributions of one-half of 1 per cent on salaries up to $5,000 by employers and employees, was introduced in the lower house late on May 16.

The measure was presented by Assemblymen Albert C. Wollenbreg, author of the Warren administration's pigeonholed compulsory health insurance bill, and Vincent Thomas, author of a similar bill sponsored by the C.I.O.

Sent to Committee

It was sent to the public health committee which was attacked by Governor Earl Warren several weeks ago for its refusal to send the health insurance bills to the floor for debates. The committee is expected to give the hospitalization bill similar treatment.

The new proposal, to be followed by another redrafted bill tomorrow reviving the original compulsory health insurance program, presents a possible form of compromise if the renewed fight for complete medical care is lost.

Effective in 1946

A.B. 2201 which would become effective October 1, 1946, provides for a maximum of thirty days hospitalization for each physical disability including necessary nursing, laboratory services, drugs, biologics, bandages and dressings. Maternity service also is provided for.

The act would be administered by an eight member hospital service authority. An executive director to be appointed by the Governor for a four year term would be paid $12,000 a year.—San Francisco *Examiner*, May 16.

ITEM VI

Sickness Pay Check Bill Now Before State Senate

Sacramento, May 10.—A weekly paycheck for every worker now covered by unemployment insurance when he is forced off the job by illness!

That is the guarantee in a bill on the Senate floor today after a unanimous approval yesterday from the Senate social welfare committee. It appears to have a good chance of final passage.

The disability unemployment insurance plan, which would make California the second state in the Nation to give its workers such broad protection, was introduced by Senator Shelley (D., S. F.)

Although not a substitute for health insurance, this measure goes a long way towards providing 2,100,000 Californians with assistance during illness.

It reaches the Senate calendar just as the new hospitalization plan, agreed upon by both Governor Warren and labor as a compromise with fair chance of passage, was due to be introduced in the Assembly. Assemblymen Wollenberg (R., S. F.) and Vincent Thomas (D., San Pedro), expect their hospitalization bill to carry more than a score of supporting assemblymen's names.

The payment for disability would be handled exactly like the payment for any other type of unemployment. The money would come from the same unemployment tax, without any change in existing rates. The weekly benefit would be the same, the overall time in which payments can be collected would be the same.

Benefits, however, would not start until a year after the bill became law. During that time the 1 per cent payroll deduction from the worker, now going into the fund along with employer taxes, would be separated into a distinct fund. This money, after accruing for a year, would be used to finance the disability portion of the unemployment payments.

A worker cannot begin to draw the money until after one week's illness. He must present a doctor's statement. He cannot collect this at the same time he is getting workmen's compensation payments. Pregnancy is not included.—San Francisco *News*, May 16.

ITEM VII

Sick Benefit Bill Beaten in Senate

Sacramento, May 18.—The State Senate today finally defeated a bill proposing to set up a sickness and disability compensation program within the framework of the California unemployment insurance fund.

With 21 votes needed to carry the motion, the Senate divided 18 to 18 on Senator John F. Shelley's motion to reconsider the vote whereby the Senate defeated the measure initially two days ago.

The bill was drafted by an interim committee on unemployment insurance after extended study. Similar to a Rhode Island plan, it would have extended benefits to persons unemployed because of illness or disability, but

unable to collect jobless compensation by virtue of being unavailable for work. The 1 per cent unemployment insurance contribution now collected from subject employees would have been diverted into a disability fund to finance the program.—San Francisco *Examiner*, May 19.

ITEM VIII

The States Are Feeling the Heat

Whatever may prove to be the ultimate fate of nationally sponsored State medicine, the agitation in its favor and the bills which have been drafted to bring it about have had the effect of building a fire under the medical profession, as well as states, municipalities and industries. The public demand for prepaid medicine is being met in at least a dozen states by various plans to provide insurance against medical expenses. The common difference between these state plans and the Federal plan, as outlined in the Wagner-Dingell-Murray bill, is that the state plans are on a voluntary basis. It seems to us an important distinction.

In Maryland the care of the poor, who are unable to pay anything for medical service, is treated as a separate problem from that of the middle class, which can afford to pay something but may prefer to participate in an insurance scheme. The very poor, the chronically ill, the insane and certain other classifications are taken care of by the state at the expense of the taxpayers. Funds are provided for an expansion of facilities for these purposes. For employed people a system of medical-care insurance is set up in coöperation with the Associated Hospitals (Blue Cross) under which citizens may purchase insurance covering specified medical services.

The plan is administered by a board of physicians and surgeons who promise that "more liberal enrollment policies and wider coverage in every field of medicine will be developed just as fast as experience warrants." Right there, it seems to us, lies the best argument for state and local voluntary insurance plans as against the vast compulsory proposals from Washington. In an area in which the limitations and possibilities of such a plan are immediately seen it is possible to relate demand to supply in a way which would be far more difficult in a national scheme planned in advance down to the last pill. Anyway, the Federal planners will do well to watch how these state insurance schemes operate.—*Saturday Evening Post*, May 19.

ITEM IX

Hearing Set on New Health Bill

Assembly Group Plans Debate Tuesday, May 29

Sacramento, May 23.—The Assembly committee on public health, which killed an earlier administration proposal for compulsory health insurance, next Tuesday will hold a hearing on a new bill setting up a modified insurance plan.

The committee, headed by Assemblyman Fred Kraft, Republican, San Diego, has set Tuesday to consider Assembly Bill 2201, by Assemblyman Albert C. Wollenberg and others, providing for a payroll deduction against both employers and employees to finance hospitalization costs. The deduction would be ½ to 1 per cent for employee and employer, compared to the 1½ per cent against each under the original full coverage measure.

Charles A. Wordell, San Francisco, president of the Association of California Hospitals, in a prepared statement today branded A.B. 2001 as "a deliberate and dangerous attempt to create a State hospital monopoly, controlled and operated by politicians."—San Francisco *Examiner*, May 24.

ITEM X

New Social Security

Cradle to Grave Bill Offered

Washington, May 24.—Legislation proposing a sweeping expansion of social security and a steep rise in the pay roll tax was laid before Congress today.

Senators Robert F. Wagner, Democrat of New York, and James E. Murray, Democrat of Montana, introduced the measure, termed an American verison of the British "Birth to the Grave" Beveridge plan, in the Senate. Representative John D. Dingell, Democrat of Michigan, sponsored the bill in the House.

Truman Backed

Wagner, who outlined the bill in an exclusive interview with International News Service eight days ago, said then that it has the backing of President Truman.

Major points of the bill propose:

1. Medical and hospital insurance for 135 million persons, through a system of prepaid health care costs.
2. Boosting of the pay roll tax on employees from the present 1 per cent to 4 per cent. Employers whose tax now averages 3½ per cent, would have their tax increased to 4 per cent under the program.
3. Federalization of unemployment compensation, now handled by the states, and an increase in amounts paid jobless workers to a maximum of $30 a week. The money would be paid for twenty-six weeks—or fifty-two weeks if funds are available.
4. A ten year, billion dollar program of Federal grants and loans for building an expansion of hospitals, health centers and related facilities. The Federal Government would pay at least 25 per cent and up to 50 per cent of the cost, depending upon a state per capita income.
5. Federal grants to states for public health services, with the Federal Government paying a minimum of 25 per cent of the costs and a maximum of 75 per cent.
6. Federal grants to states from general revenue for maternal and child health services, with again Washington paying from 25 to 75 per cent of the costs.
7. Federal grants to states for assistance to the needy —the aged, blind, dependent children and others. The Federal Government would pay at least 50 per cent of the amount spent by the State and possibly 75 per cent of the total.
8. Continuation on a permanent basis and Federal operation of the United States Employment Service.
9. Liberalization of retirement, survivors and disability insurance benefits to a minimum of $20 a month and a maximum of $120.
10. Extension of social security to 15 million persons not presently covered—farm workers, farmers, small businessmen and others.

Wagner, in introducing the far-reaching bill, said "ten years of experience with the social security act have demonstrated that we can insure people against the major causes of want. Social insurance has made our system of free enterprise operate more smoothly and effectively."

Fight Expected

Although no criticism was voiced immediately by Senators, the measure was expected to arouse bitter opposition and perhaps become one of the most controversial issues of the present Congress.

The bill would give "wage credits" of $160 a month to men and women in the armed forces for the entire period of their military service. The individual war veteran and his family would thus be insured for all social insurance benefits without deduction from his pay during military service.

Hospital care for which workers would pay through a wage tax, would be limited to sixty days a year with a possible maximum of 120 days if funds were available.

Health Plan

The health benefits of the bill would operate technically the same as unemployment compensation now does, the Associated Press reported.

Wagner emphasized that a patient could pick his own doctor or hospital or dentist; they could pick their patients, too. In that sense, he said, this is not "social medicine" which many medical men have long opposed; nor is it "regimentation," he contended.

The hospital finance plan provides $5,000 000 for the Surgeon General of the United States Public Health Service to help states survey their situations. Another $950 000 000 would be distributed over ten years, to participating States, for development of the health centers.

Full Year Pay

Provision is made for fifty-two weeks of unemployment compensation instead of the present twenty-six, if funds are available. The weekly scale would be $5 to $20 for single persons with a maximum of $30 based on dependents. Most state laws now have a top of $15 to $20.

Women would get twelve weeks maternity leave with the same scale of benefits. They would be eligible for old age assistance and widow's benefits at 60, instead of the present 65.

Old age payments would be increased to a minimum of $10 to $20 a month for single persons and $30 for a worker with a dependent wife 60 or older.

The maximum a person can earn while on pension without losing his benefits would be increased from $15 to $25 and for the blind, to $50.—San Francisco *Examiner,* May 25.

ITEM XI

Medical Care

Due partially to the activity of pressure groups, the State program for medical care was shunted early in the session of the Legislature. This was done not openly but by committee action that denied the program full public expression by the Legislature.

Now a compromise measure, sponsored by the Governor, is to come up for committee hearing next Tuesday. It provides for hospitalization, but not for some of the other benefits on which the opponents based some of their arguments. It covers less ground, will cost less and require less official machinery to put it into effect.

We believe it is the duty of the committee to report this measure out for action by the whole Legislature. The issue is of great public interest, or it would not be up now. It is important that the proposal put forward in Assembly Bill 2201 be decided by the people, through their elected legislators, and not be killed in committee. —Editorial in San Francisco *Chronicle,* May 26.

ITEM XII

Health Bill to Get New Test in Legislature

Modified Insurance Plan Slated For Debate Tomorrow

Sacramento, May 28.—With the California Medical Association again registering unaltered opposition, a modified health insurance plan is scheduled for a new test in the State legislature beginning Tuesday.

The assembly public health committee, headed by Assemblyman Fred Kraft, San Diego, has set Tuesday afternoon for hearing A.B. 2201 by Assemblyman Albert C. Wollenberg and others. This new administration sponsored measure provides for compulsory hospitalization insurance only, not insurance for general medical service.

The original health insurance bill introduced under sponsorship of Governor Earl Warren is still buried in the Kraft committee for lack of votes to send it to the floor either with or without a recommendation.

Defeat Foreseen

Many legislators are predicting a similar fate for A.B. 2201. Still others, however, predict that it will fare better than its predecessor in committee and reach the assembly, where its fate is problematical.

Meanwhile, Dr. Philip K. Gilman, San Francisco, newly-elected president of the California Medical Association, speaking with authorization of the executive committee, blasted A.B. 2201 today as "a poorly-disguised piece of political trickery, designed to enable the advocates of State medicine to get one foot in the door now and another later."

Declaring the bill is "an attempt to create a State hospital monopoly," Doctor Gilman said it contains "the same basic philosophy as the compulsory health insurance bills previously rejected by the Legislature, and would result in a State hospital monopoly." . . .—R. W. Jimerson, in San Francisco *Examiner,* May 28.

ITEM XIII

Revised Health Bill Drawn Up

Quick Hearing Set; C.M.A. Attacks Plan

Sacramento, May 28.—Prefaced by a weekend blast from the California Medical Association, a modified health insurance bill, authored by Assemblyman Wollenberg (R., San Francisco) and Thomas (D., San Pedro), is scheduled for initial hearing before the Assembly health committee tomorrow afternoon.

The committee already has killed a health insurance bill sponsored by each of the men and buried the original bill introduced under sponsorship of Governor Warren. This led to speculation in some circles that the Governor would submit a second bill of his own at a special session in a few months.

These predictions are based largely on a Washington announcement that a Federal program of health and hospitalization insurance is in prospect soon. Congressional approval is unlikely unless state concurrence is obtained, it was indicated.

First fireworks over the new bill were fired during the weekend by Dr. Philip K. Gilman of San Francisco, newly-elected president of the California Medical Association, who stigmatized it as "a poorly disguised piece of political trickery."

"It is designed to enable the advocates of State medicine to get one foot in the door now and another later," Dr. Gilman declared.

Dr. Gilman particularly attacked a provision making it a misdemeanor for any employer to require membership in any health or hospital plan as a condition of employment. This he declared "an attempt to create a State hospital monopoly."

The new measure A.B. 2201, has the joint backing of labor and Administration groups.—San Francisco *News,* May 28.

ITEM XIV

New Health Bill Deserves Approval

The new proposal to provide prepaid hospital service for the people of California, on a basis similar to unemployment insurance and old age pensions, will come before the Legislature's Assembly committee on public health at Sacramento tomorrow afternoon. The bill deserves sympathetic hearing by the committee and, after some clarifications, favorable report.

There has been offered in Congress the Wagner-Dingell bill to cover much the same ground, and California should get itself in line to anticipate whatever Federal action may be taken. We'll need such a plan if the Federal bill passes; and we will need it even more if

Federal legislation is not approved. It's high time, anyway, for states to roll their own.

This measure, known as Assembly Bill 2201, is a compromise between the original Wollenberg and Thomas bills. The former was offered to represent Governor Warren's idea of medical care; the latter represented the view of the C.I.O. A.B. 2201 would provide substantial assistance to low income groups, at a cost to employers of ½ per cent of payroll, and to employees of ½ per cent of pay received. A person becomes eligible after earning $300 in a specified period. The levy applies only to the first $5,000 of income. Self-employed persons may enroll on a voluntary basis.

The bill is not quite clear in regard to veterans, in its language concerning claims, or in its coverage of beneficiaries stricken while out of the state, but these are details. The important thing is the bill itself, its principle and its main provisions. We believe the people of California need and want this insurance against the economic ravages of illness—which are responsible for at least 25 per cent of all small loans made to individuals by banks and loan companies.

The Legislature should meet this need.—Editorial in San Francisco *News*, May 28.

ITEM XV

Hospital Health Bill

Warren—Despairing of Old Plan—Asks Action on a New One

Sacramento, May 29.—Governor Warren today urged the Legislature to approve a measure providing for a State administered system of prepaid hospitalization for all workers covered by unemployment insurance.

The Governor said the work of experts on his program shows the plan, as outlined in his bill, can be carried out at an expenditure of $7.56 a person for the 4,200,000 to be covered. This number includes the families of the workers.

In spite of adverse sentiment in the committee to which the bill has been referred, the Governor said he was "tremendously hopeful" that the Legislature, as a whole, will insist on action.

Payroll Tax

The Warren proposal provides for a 1 per cent payroll tax equally divided between employer and employee. Hospital bills for up to 30 days would be paid for under the plan.

The Governor had conceded little chance of any action by this Legislature upon his compulsory health insurance bill, which was killed off in the Assembly Public Health Committee.

Under his new proposal, introduced by Assemblyman Albert C. Wollenberg, San Francisco, the Governor hopes the Legislature will do something "to raise the health standards of the State's working people."

Up to $5,000

Contributions under the bill apply to salaries up to $5,000 a year. The entire family of an employee would be covered for the 30-day period allowed each year under the bill. This would include operating room, drugs, blood plasma, general nursing, laboratory services and maternity cases.

The number of contributors, the Governor said, would be about 2,100,000.

Contributions would amount to $38,750,000 a year, or $9.17 a person. Administrative costs are estimated at 92 cents per person a year, leaving $8.25 for the hospitalization fund.

Of this amount, only $7.56 probably would be required, leaving 39 cents from each yearly contribution to build up "a cushion."

Benefits in 1946

Payroll deductions would begin January 1, 1946, and benefits would start October 1, 1946.

The Governor said private hospital plans which are in operation provide service for only 183,744 persons, as of 1944. The average charge is from $8 to $10 a year for a single person and $18 to $24 with family coverage, for a maximum hospitalization of 21 days.

Warren said many legislators who opposed compulsory health insurance had told him they believed public hospitalization "is the answer" as a beginning of a better medical care program at this time.—San Francisco *Chronicle*, May 30.

ITEM XVI

Assembly Group Tables Warren Health Program

Prepaid Hospitalization Plan Beaten In Committee, 8 to 5

Sacramento, May 29.—The assembly committee on public health tonight tabled by a vote of 8 to 5 Governor Warren's program for establishing a system of prepaid hospitalization insurance for an estimated 4,220,000 Californians.

The committee's action was taken on motion of Assemblyman S. L. Collins of Fullerton after a three hour hearing in which spokesmen for the California Medical Association, private hospitals and the State chamber of commerce opposed the bill.

Urged by Labor

Principal argument in favor of the measure was delivered by William T. Sweigert, executive secretary to the Governor. Mervyn Rathborne of the State C.I.O. Council, and Cornelius J. Haggerty, secretary of the State Federation of Labor, voiced organized labor's support of the program.

Assemblymen Fred Kraft, Ernest Debs, Fred Emlay, John W. Evans, C. Don Field, Richard McCollister and John Thompson supported Collins' move to kill the bill. Assemblyman Edward Gaffney of San Francisco joined Ralph C. Dills, Augustus Hawkins, Jack Massion and John Pelletier in seeking to block the motion.

Out of Wages

Offered by the administration and supporters of health service legislation after original prepaid health insurance programs were defeated, the bill provides for payroll deductions of one-half of 1 per cent from both employer and employee to finance the program. Approximately 2,110,000 persons covered by unemployment insurance would contribute the added half per cent, but their families also would be eligible for benefits.

Assemblyman Albert C. Wollenberg, author of the bill, said he would move tomorrow to withdraw the bill for floor debate.

Earlier today, the Governor expressed "bitter disappointment" at defeat of his original program, but said he still had hope the Legislature would enact some type of substitute legislation at this session.

"I am tremendously hopeful that the hospitalization insurance bill will receive more kindly treatment," Warren said. "It is a very important bill, and can be made to serve a great need in our State.

Fees Cited

"Many doctors said the original, all inclusive bill put the cart before the horse in providing payment of doctors' bills. I was advised that the patient could always arrange to pay his doctor's bills, by agreement with the doctor, but that the great need of the working man is for protection when he or his family has to go to a hospital. There, he may find the door closed to him because he hasn't the money to pay for hospital fees immediately.

"I am taking these people at their word, and also, in this hospitalization plan, trying to see if we can get some sort of health program in effect this session."—San Francisco *Examiner*, May 30.

ITEM XVII

Warren Hospital Bill Tabled: Health Plan Beaten 8 to 5 in Committee

But Attempt to Be Made to Carry It to Assembly Floor

Sacramento, May 30.—For the third time the Assembly public health committee, headed by Druggist Fred H. Kraft (R., San Diego), has said "No" to a plan to give millions of California workers a prepaid health insurance system.

The hearing, which ran far past the dinner hour last night on the new hospitalization insurance proposal, representing a joint minimum plan offered by Republican Governor Warren and labor organizations, ended with an abrupt vote to table the bill, 8-5.

Assemblymen Wollenberg (R., S. F.) and Vincent Thomas (D., San Pedro), joint authors, expected today to ask the full Assembly for permission to pull the bill out of the pocket the committee has tucked it into, and get discussion and a vote on the floor. It will amount to a test vote on sentiment on the bill itself.

The committee heard the pros and cons on the hospitalization proposal in the Assembly chamber with about 50 visitors present, including many doctors.

William Sweigert, executive secretary to Governor Warren, carried the major rôle of exponent, declaring the bill does not call for State medicine, but is "an honest system of hospitalization insurance to give the benefit of a cohesive group of four million participants." He recalled Republican and Democratic convention platforms urging health plans for the people, and cited Governor Dewey's campaign speech in Los Angeles last fall calling for "organizing public and private hospitals into a system."

"This sort of program Governor Warren agrees is the only way we are going to avoid a system of State medicine," declared Mr. Sweigert. "Moderate income families now find themselves forced to turn to city, county and state hospitals without any choice when illness strikes."

Dr. Chester Cooley of San Francisco, representing the California Medical Association, declared, however, that "this is State medicine" and said it would turn many medical men into State employees. In reply, Mr. Sweigert pointed out that hospitals would volunteer to be admitted to the hospital plan.

Howard Burrell, general counsel for the Association of California Hospitals, questioned the sincerity of the bill's sponsors and said "Hospitals are to be sovietized without a question . . . lay bureaucracy can destroy the hospitals."

Only $7.50 per worker a year will be needed, Dr. Samuel May, U. S. director of public administration, said, to cover all services now proposed in the bill, including care in childbirth. Even 1940 prewar wages would yield more than that—about $8.50 he said—at 1 per cent tax (half from employer and half from employee). Present wage levels would give the fund about $12.50 per individual every year and quickly permit expansion of the services.

Charles B. Baer of the Los Angeles Chamber of Commerce disagreed with this view and predicted the revenues would be insufficient to keep up the services. Pat Merrick, State Chamber of Commerce spokesman, estimated the income would be from six million dollars to 23 million dollars short of the cost.

At conclusion of the arguments, Assemblyman Jack Massion (D., Los Angeles), also a druggist and committee member, moved the bill out "without recommendation." Assemblyman Gaffney (D., S. F.) seconded. —San Francisco *News*, May 30.

ITEM XVIII

Doctors Run a Fever

We fear some of the medicos are letting their temperatures reach the fever point over Governor Warren's efforts to do something to relieve the people of California of the heavy burden of medical care.

Comment of a Medical Association official that the new hospitalization bill is "a poorly disguised piece of political trickery, designed to enable the advocates of State medicine to get one foot in the door now and another later on" is a choleric statement far from the truth.

It doesn't help the profession's cause to indulge in that sort of loose talk. People of the State know Governor Warren is neither a radical nor a trickster. If he were indulging in political hocus pocus he never would have introduced the subject of medical care on a statewide basis. He knew it would alienate the support of a powerful group of citizens.

If the doctors were using their customary professional care of diagnosis, they would credit the Governor with being sincere but declare him mistaken, from their point of view. Pitching their fight on that basis, they would have the respect and confidence of the public.

But attacking the new hospitalization bill as "a piece of political trickery" is not likely to increase either the respect or the confidence the people have for them.

If for no other reason, the Assembly should lose no time in calling the new bill from a hostile committee—that is, if the lower house majority can spare the time from Samish-inspired legislation.—Editorial in San Francisco *News*, May 30.

ITEM XIX

Kaiser-Thomas Press Conference

Kaiser's Comments on His Medical Care Plan

R. J. Thomas, president of the United Automobile Workers (C.I.O.), stated flatly yesterday he believed "Kaiser should definitely get the Fontana steel plant."

He made the statement at a joint press conference with Henry J. Kaiser in which it was revealed that the uncertain status of the $11,000,000 California steel plant was hampering Kaiser's plans for marketing a wide variety of civilian products, ranging from automobiles to airplanes.

Kaiser is negotiating with the Reconstruction Finance Corporation to readjust the indebtedness of the Government-built, Kaiser-operated plant. Kaiser seeks authorization for a private loan of $52,000,000 for additions to convert the plant to civilian use. . . .

As an example of new fields, Kaiser said research by his own organization showed that if Kaiser plant hospital and medical facilities were duplicated on a national scale they would produce 3,000,000 jobs, and that the fields of prepaid health insurance, highway development, transportation and housing "would take care of 30,000,000."—San Francisco *Chronicle*, May 31.

ITEM XX

Re: C.I.O.—Warren Compulsory Hospital Service Bill—Assembly Bill 2201—An Analysis

A.B. 2201 was submitted in the California Legislature on May 15, 1945, by Assemblymen Thomas and Wollenberg. An analysis follows:

The bill proposes compulsory hospital care to all public and private employees and their families, financed by a 1 per cent payroll tax. It is a service and not an insurance proposal, as the benefits to the public in exchange

for the tax contributions made are in kind, i.e., in hospital service and care, and not in cash indemnification or reimbursement for expenses of hospitalization. In this respect the bill contains the same basic philosophy as Assembly Bills 449 and 800. It differs from Assembly Bill 449 and Assembly Bill 800 only in that it restricts the services rendered to hospital care and does not include medical and surgical services. The bill uses the approach of state control and government rendition of services to the people, which may be contrasted with the opposite approach found in Assembly Bill 1200 and Senate Bill 1082 (wherein the *costs* of health service are defrayed in whole or in part by cash payments to those eligible therefor), and found in existing unemployment and old age security laws (where *costs* of the necessities of life are defrayed in whole or in part by cash payments to those eligible to receive same).

The major provisions of the bill may be summarized as follows:

(1) *Administration.* A new bureau called the "California Hospital Service Authority" is created. Provision is made for employment of an executive director at a salary of $12,000 per annum. The Authority itself is to consist of seven members appointed by the Governor, plus the Director of Public Health ex officio and without the right to vote. In appointing the seven members, the Governor must select two members experienced in hospital administration, one of whom shall be a physician, two members who are representatives of employers, two members who are representatives of organized labor, and one member who is representative of agriculture. The Authority, through the executive director, is empowered to employ such personnel as is found necessary and to administer the act.

(2) *Powers of the Authority.* The chief power vested in the Authority is to prescribe minimum standards of hospital care and to fix hospital rates for all services furnished under the act (sec. 134). The Authority need not fix uniform hospital rates throughout the State. In addition, the Authority has power to adopt necessary procedures for establishment and payment of hospital bills, to review and settle disputed claims, and to investigate any hospital to determine whether it is complying with the act and the Authority's rules and regulations. The Authority is empowered to purchase or otherwise make available supplies and commodities necessary for the hospital services provided in the act (sec. 138). This power apparently assumes that the State will engage in the mass purchase of drugs, laboratory supplies, bandages, dressings, appliances, and various other commodities that are used during hospitalization. Finally, the Authority is directed to carry on continuous studies "on the degree to which the operation of the act alleviates undue financial stress on the people of California arising from the onslaught of illness or injury," and with respect to the adequate distribution of hospital facilities. In other words, using a tried and proven technique, the act contemplates that the Authority will forthwith establish a research and satistical division properly staffed with the right (sic) people, who will at the cost of the taxpayers devote their entire time to devising ways and means of increasing and extending the scope of the act.

(3) *Services included.* The act provides for hospital care for not more than thirty days for each particular disability arising from a separate cause. All employees subject to the tax levied by the act and all their dependents are entitled to such hospital care. Hospital care is defined to include ward or semi-private accommodations, the use of the usual hospital facilities, such as operating room, general nursing care, etc., the furnishing of drugs, biologics, bandages, dressings, appliances, oxygen, blood and plasma, and the furnishing of such clinical and x-ray laboratory services "as are ordinarily provided by a hospital." Hospital care excludes industrial injuries and hospitalization for tuberculosis or mental disorders after diagnosis. It is provided that a beneficiary shall only be entitled to hospitalization while a registered bed patient and under the care of a physicain. The Authority is given power to extend hospital care to include out-patient services in an emergency, special nursing services and ambulance services. These, however, are optional with the Authority.

(4) *Persons Covered.* These are divided into those upon whom the act is compulsory and those with respect to whom the act is voluntary. Compulsory coverage includes all employees subject to the Unemployment Insurance Act, together with their dependents, plus all public employees, together with their dependents. Dependents are defined as any bona fide member of the household of an employee, if such member is in fact dependent on the employee. This definition is very broad and would include wives, minor children, and all adults who live in one household with respect to whom the wage-earner is a source of support. Public employees are defined to include the employees of the state, and county, city, municipality, district, or other political subdivision. This means that every public agency in this State is within the compulsory provisions of the act. Section 36 of the bill provides that an employee includes "public officials, whether elected or appointed." Accordingly, the Governor, the members of the Legislature, the members of the State Supreme Court, and in fact all public officials or employees are within the compulsory tax provisions and benefits.

Persons not within the compulsory provisions of the bill may elect to obtain voluntary coverage. If they so elect, they must acquire coverage by virtue of membership in some bona fide organized group, organized for purposes other than securing hospitalization (sec. 110). Inasmuch as farmers and self-employed businessmen are about the only persons not within the compulsory provisions, this means that such people could only acquire coverage through some organization which could contract with the Authority. The act provides that the Authority, in entering into any contract for voluntary coverage, may fix the contribution rates at such amount as it deems necessary. Section 111 provides that any public or private employee who becomes unemployed may continue as a beneficiary by making periodic payments to the Authority in such amounts as the Authority may determine to be equitable. This section adopts the policy which most voluntary prepayment plans now have in effect, viz., permitting an individual who leaves a group to continue membership by making payments on an individual basis.

Based on the fact that in 1944 approximately 2,200,000 persons were covered under the Unemployment Insurance Act, and estimating that there are probably at least 100,000 public employees in this State, it is estimated that under the liberal definition of dependent contained in the bill, the total number of people subject to the compulsory provisions would probably be in excess of 6,500,000. This figure, of course, does not take into account the exemptions hereinafter described.

(5) *Finances.* The bill provides that the costs of hospital services and administration of the act are to be met by a 1 per cent payroll tax, payable ½ of 1 per cent by the employer and ½ of 1 per cent by the employee. The tax is limited to the first $5,000 of wages paid to any employee in any calendar year. The tax is payable by all employing units that are subject to the Unemployment Insurance Act, plus all public agencies.

(6) *Exemptions.* First, all employers and employees, except public agencies and public employees, who are now

exempt under the Unemployment Insurance Act will likewise be exempt from the compulsory hospital service act, as the definition of "employer" and "employee" are the same in both acts. Second, under section 88 of the bill, all persons who adhere to any religion that depends for healing upon prayer, and all veterans of any war in which the United States has been or is engaged, may elect to be exempt from the taxes imposed by the bill and the hospital service benefits. Under section 88, if an employee elects to claim exemption because of religious belief or military service, his employer becomes exempt from the employer's portion of the 1 per cent tax. Exempting the employer from the tax as well as the disclaiming employee means, of course, that any employer who would restrict his employment to Christian Scientists and war veterans would have an advantage over his competitors to the extent of ½ of 1 per cent of his payroll.

(7) *Miscellaneous:*

(a) *Free Choice.* Section 139 of the bill provides that free choice of physician and hospital shall be maintained.

(b) *Administrative expenses.* Section 183 of the bill limits administration expenses to 8 per cent of taxes paid during the first three years of operation and 5 per cent thereafter.

(c) *Voluntary plans.* Section 199 of the bill provides that it is a misdemeanor for any employer to require membership in any "health" or hospital service plan as a condition of employment. The section also provides that any such condition in any contract of employment is void. Apparently this section is aimed at destroying existing voluntary medical and surgical prepayment plans. In many instances, employers pay the full cost of membership in voluntary medical prepayment plans; under this section such an employer would be guilty of a misdemeanor, because quite naturally where full cost is paid by the employer membership in the plan is a condition of employment. Also, for voluntary prepayment medical plans to secure adequate distribution of risk, maximum employee participation is essential. Section 199 seems to be aimed at impeding such distribution of risk.

(d) *Effective date.* The bill provides that the 1 per cent tax shall commence January 1, 1946, and that the hospital benefits shall commence October 1, 1946, but section 7 of the bill permits the Governor to defer these effective dates for periods of six months, as long as the United States continues in a state of war.

* * *

COMMENT

From the foregoing summarization of the bill, we have the following comments with respect to its effect upon the medical profession: While the bill only covers hospital care and a few professional services such as clinical laboratory and radiological services, it is nevertheless of vital importance to every physician and surgeon. We pointed out at the outset that the bill is a *State control,* not a cash indemnity, proposal. If the bill should become law in its present form, the State of California would in a very short time be the owner of all of the hospitals in this State, for all practical purposes. The bureau created by the bill is expressly given power to fix hospital rates. It is self-evident that the power to fix rates is the power to control completely. No hospital could do anything but obey meekly the orders emanating from the Authority, for otherwise rates could be fixed at less than cost (bearing in mind that the bill provides that rates need not be uniform), and offending hospitals forced to close their doors. That rates might be fixed at less than cost is no idle fear, when it is borne in mind that the Children's Bureau of the United States Department of Labor did just exactly that when given a sum of money by Congress to expend for infant maternity care for the wives and children of enlisted men. With the hospitals of the State at the mercy of a government bureau, the practice of medicine in such hospitals would be tremendously affected. The hospital, instead of being the doctor's workshop, would soon become the doctor's master. Government employees would be in a position to dictate to every hospital every minute detail of practice therein.

It is also clear that the proposed compulsory hospital service bill is intended as an opening wedge leading ultimately to State medicine. The way the bill is drafted it would require only an increase in the payroll tax and the addition of one or two paragraphs to add medical and surgical services to the benefits. You will recall that we mentioned above that the Authority is directed by section 136 of the bill to carry on continuous studies with respect to the degree of relief afforded by the compulsory hospital act. The only apparent purpose for such section is to permit the Authority to establish a propaganda section, so that during the interval between this and the next session of the Legislature the thinking of the Legislature can be conditioned to a point where it will seem but a minor step to add medical and surgical services to the act.

In connection with the bill it should be borne in mind that, due to California's increased population and war conditions, the present hospital facilities are barely adequate to take care of existing needs. The effect of the bill, if it becomes law, will be to increase the demand for admissions to hospitals and thus add to the already strained situation. The United States Congress now has before it Senate Bill 191 which proposes a nation-wide survey of hospital facilities and grants in aid to the several states a total sum of $100,000,000 for the purpose of building new hospitals where needed. Assembly Bill 600, now before the California Legislature, proposes to create a California commission for the purpose of making the hospital survey in this State contemplated by the Federal act. It would seem to us that public welfare would be better promoted by attacking the problem of securing more hospital facilities first, before undertaking a program that would increase the demand upon such facilities.

PEART, BARATY AND HASSARD.

ITEM XXI

A.M.A. Decries Health Bill

The *Journal of the American Medical Association* declared editorially on May 31, that Senator Wagner's newest proposal for nationwide medical care "still is socialized medicine."

The *Journal* specifically attacked phases of social security legislation, embodying the proposed hospital insurance program, as proposed by the New York Senator.

"Most people with any understanding of the situation," the *Journal* said, "will insist that compulsory sickness insurance with Federal control is both socialized medicine and State medicine."

Senator Wagner's "emphatic assertion" that each person is entitled to choose his own doctor is true only in that he is free to choose among physicians agreeing to go into the insurance system, the *Journal* said.

The editorial, moreover, complained that the majority opinion of the 125,000 physicians who comprise the A.M.A., was "completely disregarded" in the drafting of the bill.

It termed the "Medical Forum," which Wagner said he had consulted, "a group of several hundred physicians, mostly inclined toward Communism and practically all living in New York City."—San Francisco *Chronicle,* May 31.

ITEM XXII

Gov. Warren for Any Workable Health Plan

Sacramento, May 31.—Declaring that he still stands in readiness to accept any amendment that will bring about passage of a workable health or hospitalization insurance bill, Governor Earl Warren today declared that a "terrible responsibility" rests on the "solid phalanx" of those opposing his health program.

The Governor's statement, made at his press conference, obviously was to strengthen the position of Assemblyman Albert C. Wollenberg tomorrow, when Wollenberg makes his fight to withdraw the hospitalization bill from the Assembly public health committee. The committee voted 8 to 5 two days ago to table the measure.

"All we try to do in the bill," Warren explained, "is to give the average citizen who can't afford the expenses of hospitalization the right to work out his problem in a democratic way—to go where he wants and to get the service he needs."

Criticisms that the program would "Sovietize medicine" were denounced by the Governor as "pure buncombe" and those who try to "cloud the issue by such talk," he asserted, "are assuming a terrible responsibility."

"California is way behind the times," Warren said, "so far as hospital space is concerned. We have two million new population in the State, veterans are coming back in large numbers, and another great epidemic such as the flu which followed the first World War would find us so far behind in hospital facilities that we would have thousands of unnecessary deaths."

Warren said that if—and he emphasized the "if"—he was sure that after six months of study, enough legislators would be convinced of the need for health insurance to pass a bill at that time, *he would call a special session for the purpose.*—San Francisco *Examiner*, June 1.

ITEM XXIII

Legislature to Renew Battle on Health Plan

Compulsory Insurance Only Issue Left Before Adjournment

Sacramento, June 2.—With health or hospitalization insurance the only remaining major issue, the Legislature today was giving serious thought to final adjournment following passage yesterday of the biennial budget bill and the Administration's program for continued tax reduction.

June 16 was declared to be the earliest possible date for ending the session.

Governor Earl Warren today sent the Legislature a special message urging passage of Assemblyman Albert C. Wollenberg's Assembly Bill 2201, providing for compulsory hospitalization insurance for all persons now covered by unemployment insurance and for their families and dependents.

Once Tabled

Whether his direct appeal to the Legislature will win approval for hospitalization insurance remained problematical, however. A.B. 2201 was tabled by the Assembly public health committee, and it cannot be taken up by the lower house unless the Assembly votes to withdraw the bill from committee.

Wollenberg said he would make a motion to withdraw early next week. On April 10, he moved to withdraw the general, all-inclusive health insurance bill from the same committee, and was defeated by a vote of 39 to 38.

With sentiment against this type of social legislation apparently increasing, as judged by the committee's action, many observers expressed doubt that even Warren's personal intervention would get it out of the unfriendly Public Health Committee.

Warren's deep interest in enactment of some type of health legislation was further indicated two weeks ago when he sent his executive secretary, William Sweigert, to make the chief presentation in behalf of A.B. 2201 before the committee.

The Governor, in his message, dwelt on the unpredictability of the need for hospitalization, on its heavy cost, and the "need for spreading the risk among more than two million employed persons in the State by means of a payroll contribution of ½ of 1 per cent and a similar contribution by their employers.

"Beneficiaries would have the right to make their own arrangements for more expensive hospital accommodations than those provided for in the act," he wrote, "by payment of the difference in rates."

Assembly Speaker Charles Lyon said if the Governor signs the budget bill on Monday, it should be possible to adjourn sine die on Saturday, June 16. . . .

Many veteran legislators said Lyon's proposal for June 16 adjournment was too optimistic, and that the session would run to the following weekend.—San Francisco *Examiner*, June 3.

ITEM XXIV

Final Health Bill Debate On

Sacramento, June 4.—Hospital insurance, the minimum health provision Governor Warren hopes to win for California families from this Legislature, is not an isolated, local scheme it developed today.

The bill, for which final battle was due on the floor of the Assembly today, has its counterpart in the Wagner-Murray social security bill introduced into the U. S. Senate ten days ago.

The Federal measure opens with an entirely new proposal for a vast nationwide hospital construction and improvement program which anticipates some state agency, ready to receive its share of Federal money, set hospital standards and work towards improved health conditions.

Copies of the Wagner-Murray bill have just reached the *News* and show an entirely new emphasis on a 10-year plan for "providing better health and medical services through the construction, improvement or enlargement of needed hospitals, especially in rural communities, in economically depressed areas and in areas in which existing hospitals are overtaxed as a consequence of the war."

The bill calls for five million dollars for states to study their needs; 50 million dollars for the 1945-46 fiscal year construction; 100 million dollars for each of the succeeding years, to be split among all the states in grants or 20-year loans available to states, counties, health or hospital districts, other political subdivisions or even nonprofit organizations.

This permits participation by any private agency owning and operating a hospital, in which no part of the net earnings benefit any private shareholder or individual.

While this national "hospital and health center construction act" is mainly aimed at improving or increasing hospital facilites, it is directly in line with Governor Warren's statements of what he hopes can be provided California.

He has emphasized in press conferences his desire to set up a hospital agency prepared to accept Federal money, should this or other somewhat similar legislation pass Congress.

The Wagner-Murray bill also calls for health insurance. It is a bulky 185-page document which largely redrafts the Social Security Act. A new version of the cradle-to-the-grave protection. It calls also for disability unemployment insurance, for extension of unemployment payments in time, and enlargement of them to workers with dependents. It was buffeted about in Congress last year, and is out for a new try this time.

But it starts off with the concrete plan for building hospitals, and to share this building, each state must designate a single state agency for administration, and plan for state financial participation. It must have a hospital advisory council and a hospital construction program with projects listed according to priority of need.—Mary Ellen Leary, in San Francisco *News*, June 4.

ITEM XXV

Hospital Health Bill Killed

Sacramento, June 4.—Governor Earl Warren's hospitalization insurance bill was given its final death blow in the Assembly today, accompanied by a crackle of verbal firecrackers that kept Capitol corridors echoing with the word "lobbyist" for three hours.

Warren Hit

Among those who used the word "lobbyist" in referring to recent activities here were Assembly Speaker Charles W. Lyon, who heatedly asserted from the rostrum that Warren had placed himself "in the position of lobbying" for the hospital insurance bill; and Governor Warren, who, when informed of Lyon's remarks, suggested sharply that "this might be an appropriate time" for a "full and impartial investigation" of lobbying activities.

Better Debate

Lyon's statement climaxed a brief but bitter debate on a motion by Assemblyman Albert C. Wollenberg to withdraw the administration sponsored compulsory hospitalization insurance bill from the public health committee. Wollenberg began his closing argument by announcing that he would read a special message on the subject sent by Warren to the Legislature last week, and printed in both the Senate and Assembly journals. Assemblyman Chester Gannon raised the parliamentary objection that the message went into the merits of the legislation and was therefore out of order in discussing a motion to withdraw the bill from committee.

"I don't see how a statement by the Governor——" Wollenberg started to reply.

Lobbying Charge

Lyon banged his gavel, and shouted angrily:

"He is placing himself in the position of lobbying on a bill, which he has no right to do."

Wollenberg heatedly defended Warren's right to send the message, outshouting Lyon, and challenged his use of the word "lobbyist."

"When he sends a message like that, he is reducing himself to the position of a public relations man," Lyon retorted.

Lyon won the argument, and within a few seconds the vote was taken on Wollenberg's motion to withdraw the hospitalization insurance bill from committee. It lost, 32 ayes to 45 noes, as compared with a vote of 39 to 38 a month ago on a motion to withdraw from committee the administration's general compulsory health insurance bill.

Warren Answer

Governor Warren, informed of the battle in the Assembly declared that "of course" he advocated the bill, not as a lobbyist, but "as Chief Executive of the State charged with recommending to the Legislature measures which in my opinion are for the welfare of the people."

He quoted from the constitution on his duty to recommend "such matters as he shall deem expedient," and then turned to the section on lobbying, commenting, "There seems to be some confused thinking on what constitutes lobbying." The section makes it a felony to seek to influence a legislator's vote through bribery, promise of reward, intimidation or other dishonest means.

"I can see no connection between the two," Warren said.

Asked if he construed Lyon's remarks as accusing him of lobbying in the criminal sense of the word, Warren replied:

"I'm not here to construe."

Speaker Lyon explained that "there has been no charge by me or anyone else that the Governor was guilty of legally improper lobbying." He agreed that Warren was within his rights in recommending enactment of a health or hospitalization insurance bill, and also in sending the special message last Saturday.

Message Cited

"But the special message," Lyon said, "was nothing more nor less than an argument in favor of the hospitalization bill. In other words, the Governor was using his prerogative to try to persuade the Legislature to adopt a measure he was advocating."

The vote on withdrawing the bill from committee found both Republicans and Democrats ignoring party lines.—R. W. Jimerson, in San Francisco *Examiner*, June 5.

ITEM XXVI

Congress Gets New Wagner-Murray-Dingell Plan For Social Security

Washington, May 24.—(A.P.)—A new, broad concept of social security, including health insurance, was introduced in Congress today with a plea that the Nation needs it as a postwar bulwark.

The far reaching measure, increasing costs to both employees and employers, was proposed by Senator Wagner, Democrat of New York, and Representative Dingell, Democrat of Michigan.

Lists Benefits

Wagner, explaining the legislation in detail in a speech prepared for the Senate, listed these principal proposals:

1. Contributions of employers and employees would be increased from 1 to 4 per cent each.

2. Every citizen would be eligible to health insurance similar to the present voluntary hospital insurance plans now in effect. None of the current plans would be affected; they could continue in business.

3. The Government would embark on a 10 year plan, with an appropriation of $950,000,000 to help states build and improve hospitals and health centers, especially in rural areas. An additional $5,000,000 would be provided to help the states make the necessary surveys.

USES Would Take Over

4. The United States Employment Service would be established permanently. After the war it would take over the War Manpower Commission and other related services within the social security board setup.

5. Social security coverage would be extended to an additional 15,000,000 persons, including farm workers, domestics, those in nonprofit institutions and the independent farmer, professional person and small businessman.

6. Increases would provide for unemployment compensation and old age benefits; the jobless insurance would be nationalized, rather than operate on a state by state basis.

Endorsed By Labor

Wagner said labor organizations endorse the bill.

He emphasized that the health insurance plan would allow the individual to choose his own physician and hospital; would permit the physician and hospital to pick their own patients, too.

"It is not socialized medicine," he insisted.

The Senator said full employment, if it is achieved after the war, "still does not solve the economic problems of widows and orphans, the aged, the sick and disabled."

The medical care insurance would provide for hospital service up to 60 days a year, with the insured person's family included in the benefits.

For illness or disability, a person would get the same payments as if unemployed, and these would be revised.

Extended Unemployment

Duration of unemployment benefits would be extended from the present maximum of 26 weeks to a full year if

available funds permitted. The weekly scale would be from $5 to $20 for single persons, with a maximum of $30 based on the number of dependents. Most existing state laws have a maximum between $15 and $20.

Women workers would be allowed 12 weeks maternity leave, with the same scale of benefits.

Changes in the old age assistance phase would provide monthly cash benefits where the worker is totally disabled for six months or more before reaching retirement age. The minimum monthly sum would be increased from $10 to $20 for a single person, and $30 for a worker with a dependent wife aged 60 or more. The maximum would be $120 a month. The bill also would lower from 65 to 60 the retirement age for women and for receiving widow's benefits.

Armed Service Credit

Those in the armed forces would be granted a wage credit for $160 a month, thus having this social security credit during their period of service without deductions from Army or Navy pay.

Wagner said the program would pay "enormous dividends" in public health. The aid to states and the health insurance plan, he contended, would provide medical care for the low income family and strike "at an important cause of the shockingly high rate of rejections" experienced by draft boards.

"Health insurance does not involve regimentation of doctors or patients," he declared. "It is simply a method of assuring a person ready access to the medical care that he or she needs by eliminating the financial barrier between the patient and the doctor or hospital."

Wagner said the legislation is not the "final solution" of social problems, but simply "a desirable step that can be put into operation now."

—Sacramento *Bee*, May 24, 1945.

ITEM XXVII

"Legislative Bulletin" of the Public Health League of California

Hotel Sacramento

Sacramento, California

June 6, 1945 Number 5

Compulsory Hospitalization Bill (A.B. 2201) Killed

Governor Warren's compulsory hospitalization bill was killed in the Assembly Tuesday when that body, by a vote of 45 to 32, refused to over-ride the recommendation of its Public Health Committee and withdraw the bill from that Committee.

The bill, Assembly Bill 2201, was introduced on May 15 by Assemblyman Wollenberg of San Francisco, who was the principal author of the Governor's original compulsory health insurance bill, and Assemblyman Thomas of San Pedro, who was author of the C.I.O. bill. Joining these two were Assemblyman Anderson, Los Angeles; Brady, San Francisco; Berry, San Frnacisco; Burns, Eureka; George D. Collins, San Francisco; Crichton, Fresno; Dekker, Hollywood; Dunn, Oakland; Fletcher, Long Beach; Gaffney, San Francisco; Hawkins, Los Angeles; John C. Lyons, Los Angeles; Maloney, San Francisco; Massion, Los Angeles; McMillan, Los Angeles, and Rosenthal, Los Angeles.

The bill was actively supported by the Governor, the C.I.O., the A.F.L., and P.T.A., and the League of Women Voters.

It was given a lengthy hearing in the Public Health Committee on May 29. William Sweigert, executive secretary to the Governor, pleaded for more than an hour in behalf of the bill. Numerous other witnesses were presented by the C.I.O. and A.F.L.

The opposition to the bill was presented by Howard Burrell, chief counsel for the Association of California Hospitals, who declared the measure would "sovietize" the hospitals of California. Dr. Chester L. Cooley of San Francisco presented the opposition of the California Medical Association and pointed out that the bill was similar to the original compulsory health insurance bills which had been killed by the Assembly. Opposition of business groups was presented by Charles Bayer of the Los Angeles Chamber of Commerce and Pat Merrick of the California State Chamber of Commerce.

Bill Was Tabled

After lengthy consideration, the committee tabled the bill by a vote of 8 to 5. Voting to table the bill were: Assemblymen Sam L. Collins, Fullerton; Fred Emlay, Salinas; John Evans, Los Angeles; Don Field, Glendale; Richard McCollister, Mill Valley; John Thompson, San Jose; Fred Kraft, San Diego; Ernest Debs, Los Angeles. Voting against the motion to table were Assemblymen Ralph Dills, Compton; Edward Gaffney, San Francisco; Gus Hawkins, Los Angeles; Jack Massion, Los Angeles; John Pelletier, Los Angeles.

On June 2 the Governor sent a message to the Legislature urging the passage of the bill, in support of the motion by his floor leader, Assemblyman Wollenberg, to override the action of the Public Health Committee and bring the bill to the floor of the Assembly. The air in the Assembly was tense when Assemblyman Wollenberg called up his motion for vote on Tuesday afternoon. He was aided by Assemblyman Gaffney of San Francisco and Miller of Palo Alto. Assemblyman Kraft of San Diego and Debs of Los Angeles took the floor in opposition to the motion to withdraw the bill.

During the procedure, Speaker of the Assembly, Charles W. Lyon of Beverly Hills, ruled "out of order" an attempt by Wollenberg to read into his closing argument the Governor's message urging enactment of the bill. Speaker Lyon said: "The Governor has placed himself in the position of lobbying for this bill, which he has no right to do." In further ruling Wollenberg out of order, Speaker Lyon said, "The Governor is reducing himself to the position of a public relations man when he does what he did."

Action of the Assembly apparently kills the compulsory health insurance issue for this session of the Legislature. The Governor has indicated he may call a special session to consider this subject, and the C.I.O. has threatened to place it on the ballot by initiative.

The vote on Tuesday, June 5, was even more decisive than the defeat administered to the compulsory health insurance bill on April 10. Tuesday vote was 45 to 32; the April 10 vote was 39 to 38.

Voting to Withdraw from Committee: Anderson, Hawthorne; Beck, San Fernando; Bennett, Los Angeles; Berry, San Francisco; Brady, San Francisco; Brown, Modesto; Burns, Eureka; Carey, Emeryville; Collins, George D., San Francisco; Crichton, Fresno; Dekker, Los Angeles; Dills, Ralph C., Compton; Doyle, Los Angeles; Dunn, Oakland; Fletcher, Long Beach; Gaffney, San Francisco; Haggerty, San Francisco; Hawkins, Los Angeles; Heisinger, Fresno; Kilpatrick, Los Angeles; Lyons, Los Angeles; Maloney, San Francisco; Massion, Los Angeles; McMillan, Los Angeles; Miller, Palo Alto; O'Day, San Francisco; Pelletier, Los Angeles; Rosenthal, Los Angeles; Sheridan, Oakland; Sherwin, Piedmont; Thurman, Colfax; and Wollenberg, San Francisco.

Voting Against Withdrawal From Committee: Allen, Los Angeles; Armstrong, Redlands; Beal, Los Angeles; Boyd, Palm Springs; Burke, Alhambra; Burkhalter, North Hollywood; Butters, Brawley; Call, Redwood City; Clarke, Le Grand; Collins, Sam L., Fullerton; Crowley, Fairfield; Davis, Los Angeles; Debs, Los Angeles; Dickey, Alameda; Dills, Clayton A., Gardena; Emlay, Salinas; Erwin, Puente; Evans, Los Angeles; Field, Glendale; Fourt, Ventura; Gannon, Sacramento; Geddes, Pomona; Guthrie, Porterville; Hollibaugh, Huntington Park; Johnson, Berkeley; King, Orovile; Knight, La Canada; Kraft, San Diego; Leonard, Hollister; Lowrey, Rumsey; Lyon, Beverly Hills; McCol-

(Concluded on Page 320)

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Rights of Medical Officers in Armed Services to Practice in California

(COPY)

STATE DEPARTMENT OF JUSTICE
Office of Attorney General Robert W. Kenny

Monday, May 28, 1945.

Army and Navy medical officers not holding California licenses, may treat military personnel outside of a military reservation or at a military hospital only in case of emergency and as an official duty to the armed forces, Attorney General Robert W. Kenny, head of the State Department of Justice stated today in an opinion.

His ruling was requested by the State Board of Medical Examiners.

Kenny said, "Army and Navy medical officers may in an emergency situation, treat the dependents of military personnel since the health and welfare of such dependents bear directly upon the morale and efficiency of the members of the armed forces.

"Except in the case of such emergencies and as an official duty, no medical treatment may be administered by unlicensed medical officers to non-military personnel in any non-federal area within the State of California."

The opinion was prepared by J. Albert Hutchinson, Deputy Attorney General.

U. S. Casualties Pass Million

Washington, May 31.—The War and Navy Departments announced today that Amercian armed forces have suffered more than a million casualties in three and one half years of war.

To emphasize the "stern cost of victory," Acting Secretary of War Robert P. Patterson made public figures showing the heavy casualties sustained by some of the American infantry divisions in Europe. He said that the heavy fighting in the western Pacific gives notice of what may be expected as the war moves against Japan's inner empire.

Without including all losses sustained in the current battle at Okinawa, the War and Navy Departments reported total casualties of 1,007,285, including 227,552 killed, in the Army, Navy, Marine Corps, Coast Guard and Merchant Marine.

In addition to the dead the total includes 606,298 wounded, 68,029 missing, and 105,406 prisoners of war.

United States Army casualties as reported to Washington through May 21, and reflecting actual fighting to the beginning of May totaled 890,019. This included 183,563 killed, 553,088 wounded (309,646 have returned to duty), 52,746 missing, and 100,622 prisoners.

Secretary Patterson said that approximately 90,000 American prisoners of war have been recovered in Europe. This represents substantially all the American personnel captured by the enemy in the European fighting.

Patterson indicated that about 50,000 men heretofore listed as missing are not likely to turn up as prisoners and probably have been killed.—San Francisco *Examiner*, June 1.

11,000 Amputations Cared for in U. S.; 4,000 Quit Army

Washington, May 19.—(A.P.)—The War Department reported today that 11,000 amputation cases had been treated in Army hospitals in the United States up to May 1.

Approximately 5 per cent of the soldier patients have lost more than one limb, but none has completely lost both arms and legs. Six have lost three limbs and one lost part of four limbs as a result of freezing after an airplane crash.

Of the 11,000, approximately 4,000 have been discharged.—San Francisco *Call-Bulletin*, May 19.

The Story of Our War Wounded

London, May 27.—(A.P.)—Fewer than 100,000 patients remain in Army hospitals in the European theater of operations and practically all of them will be restored to duty here or returned to the United States by mid-July, Major General Paul R. Hawley declared on May 28.

The theater's chief surgeon said in an Army Hour broadcast that the death rate among American Army battle casualties in this war was less than half that of World War I.

Of 1,375,000 U. S. soldiers and sailors hospitalized in the European theater since the beginning of the war—about one-fourth of whom were battle casualties—fewer than 13,000 have died, Hawley said.

Several factors achieved this, he continued, and "first in importance, I think, was the devotion of medical officers and soldiers with the combat troops. More than 2,000 of these brave people were killed in action and almost 10,000 wounded.

"Next, we had as fine doctors as America can produce. We had an ample supply of whole blood and blood plasma, plus the miracle sulfa drugs and penicillin, better nutrition, and sanitary controls."

In the war against Germany, medics used about 325,000 pints of whole blood and approximately 1,000,000 pints of reconstituted blood plasma, he added. Civilians at home furnished 195,000 pints of whole blood and soldiers over here 140,000 pints.—San Francisco *Chronicle*, May 28.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Alameda County Medical Society

In the *Bulletin* of the Alameda County Medical Association, President Harry J. Templeton called attention to the appointment of an executive secretary and business manager, as follows:

(COPY)

PRESIDENT'S MESSAGE

After our Council and our membership had authorized the application of business principles to our society, it was neessary to select a competent Business Manager. For the success of such a plan hinged largely upon the ability of this man. Mr. Waterson had so impressed our members by his outline of what had been accomplished in Lake County, Inidana, that many of you came to me immediately after his address and urged me to try to hire him. You felt, as I did, that with him as our Business Manager the uncertainties, the dangers of an inexperienced man and the breaking-in period would be eliminated. Therefore, a committee consisting of Past President Donald Lum, Vice-President Warren Allen, Secretary Gertrude Moore and myself propositioned Mr. Waterson with the result that he has agreed to accept the position. Unfortunately, he cannot begin work with us until June 1 or July 1. Meanwhile, however, he will

keep in close touch with us and will advise us as to preliminary steps to be taken.

I want to thank all of you for approving of this, my pet scheme. It seems to me that if we all work hard and coöperate with Mr. Waterson we have the opportunity of making the Alameda County Medical Association one of the most successful and active associations in the country. We can develop our own business office, credit rating bureau, collection service, telephone service and monthly bulletin. But more important than this, in these critical times, we can embark on a public relationship campaign that will materially strengthen the position of medicine in Alameda County.

The project will probably be self supporting, or nearly so, after a year. To finance the first year an assessment will be necessary. It is my belief that any monies that you spend for this purpose will be an extremely worth while investment.

* * *

Mr. Rollen Waterson, our Business Manager [Mr. Waterson comes from Lake County Medical Society of Gary, Indiana, where he has also acted as secretary of the American Association of Physicians and Surgeons], will probably be with us before our next meeting. He is due to leave Indiana about May 15; so it won't be long now until we shall have to get to work with him to organize our County Medical Society so that it will be the most active and progressive one in the country.

After correspondence with Mr. Waterson, and after conferences with our officers and councilors, we have rented the entire fifth floor of the Income Securities Building at 364 14th Street, Oakland, for our business office. This office has the central location which Mr. Waterson feels is essential for contact with the public, with business, with newspapers and as a place for our collection and telpehone bureaus.

At Mr. Waterson's request we have selected an attorney, Mr. Harold Huovinen, to advise us in organizational business and tax problems. Mr. Huovinen has always been a friend of medicine and is attorney for the Hospital Service of California. He is well qualified for the position.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Nation's Hospitals Are Great Health Asset, Says Chamber of Commerce Committee

The importance of hospitals to the nation's health is indicated by the fact that during 1944 more than 16 million patients—approximately 1 of every 8 persons in the United States—were admitted to hospitals, according to a spokesman of United States Chamber of Commerce Health Committee.

The American Medical Association's 1944 Hospital Census shows that hospital admissions for 1944 were the largest in history, that patients entered hospitals at a rate of approximately 1 person every 2 seconds, and that hospital service in the United States has more than doubled in the last 10 years.

In addition, 1,919,976 infants were born in hospitals during 1944—at the rate of 1 live baby every 16.4 seconds, the A.M.A. report shows.

The A.M.A. Census shows that there were 6,611 registered hospitals in 1944. Although this was 44 fewer hospitals than were reported in 1943, the total capacity of 1,729,945 beds is a gain of 80,691 beds, the report states.

The great increase in hospital service in recent years is due to an increase in public understanding of the importance of good hospital and medical care, rather than to an increase in illness.

Hospitals are of great importance to the health of the people, said the U. S. Chamber spokesman, because of the important part they have in the training of thousands of doctors and nurses each year, as well as because of their place in caring for the sick.

Hospital Day

Praise Given Doctors, Nurses

San Francisco's 18 major hospitals observed National Hospital Day on May 12, in keeping with a proclamation by Mayor Lapham designating the 125th birthday of Nurse Florence Nightingale as a reminder of "the outstanding wartime service" of the city's hospitals and personnel.

Under the theme "Hospitals Fight on Two Fronts," the San Francisco hospital conference today paid tribute to doctors, nurses and technicians—both in the Armed Services and on the home front—for their accomplishments during a time of unprecedented difficulties, according to Charles J. Malinowski, president.

With fewer civilian hospitals and a large decrease in personnel, our institutions still have managed to care for more civilian sick than ever before, he pointed out. One reason for the increase in civilian care is the birthrate, with 1,919,976 babies born in hospitals in 1944.

More than 60,000 doctors and 54,000 nurses are now in the Armed Services. More will leave the ranks of 135,000 student nurses now in training.

Overall gains by community hospitals through the years include more than eight years added to the average length of life, with the average age now 62.8 years, and infant mortality reduced more than 50 per cent.

As their postwar project, hospitals plan to expend more than a billion dollars in new buildings and equipment and to continue to expand the nonprofit Blue Cross payment plan for hospital care. More than 37 million Americans now are covered by hospital insurance, it was said.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

Wartime Graduate Medical Meetings

CLINICS, DEMONSTRATIONS, LECTURES

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

Authorized by the Surgeons General, Norman T. Kirk, Ross T. McIntire, Thomas Parran

Committee 24th Zone

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman
Capt. Harry P. Schenck (MC), USNR
Wayland A. Morrison, M.D.
James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) for the last two weeks of May, follows:

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

March Field, Riverside, California—Tuesday, May 15, at 1530

"War Wounds of the Chest"—Lt. Comdr. Joseph P. O'Connor and Lt. Henry Jaffe of U.S.N.R., San Diego.

Torney General Hospital, Palm Spring, California—Tuesday, May 15, at 1530

"Repair of the Facial Nerve"—Dr. Peter Viole of Los Angeles.

Santa Ana Air Base, A.A.F. Regional Hospital, Santa Ana, California—Tuesday, May 15, at 1930

"Comparison of Protozoal and Bacillary Dysenteries"—Dr. John Kessell, Professor Bacteriology, University Southern California, Los Angeles.

Camp Cooke, Station Hospital—Wednesday, May 16, at 1300

Intestinal Obstruction Due to Regional Enteritis"—Lt. Col. Wm. C. Sheehan, MC, Chief of Surgical Branch, Birmingham General Hospital, Van Nuys and Major Ralph Pomeranz, MC, Chief of X-ray Service.

Hoff General Hospital, Santa Barbara, California—Wednesday, May 16, at 2000

"Intestinal Obstruction Due to Regional Enteritis"—Lt. Col. Wm. C. Sheehan, MC, and Major Ralph Pomeranz, MC.

USATS, San Diego, California—Friday, May 18, at 1500

"Allergy"—Dr. Robert W. Lamson, of Los Angeles.

Birmingham General Hospital, Van Nuys, California—Wednesday, May 23, at 1500

"Traumatic Surgery of the Abdomen"—Dr. Charles E. Phillips of Los Angeles, and Comdr. Gaylord Bates of U.S.N.H., Corona.

U.S.N.H. Santa Margarita Ranch, Oceanside, California Thursday, May 24, at 1300

"Malingering Tests"—Dr John Mackenzie Brown of Los Angeles.

U.S.N.H., Corona, California—Thursday, May 24, at 1300

"Tumor Pathology"—Comdr. John W. Budd, U.S.N.-A.A.S., Los Alamitos, Calif.

U.S.N.H., Long Beach, California—Wednesday, May 16, at 1500

"The Classification and Diagnosis of the Anemias"—Dr. Alvin G. Foord of Pasadena.

* * *

The following is a list of the Wartime Graduate Medical meetings which are scheduled for the month of June.

U. S. Naval Air Training Station, San Diego, Friday, June 1, at 1500

"RH Factor"—Capt. George Macer, MC, A.A.F. Regional Hospital, Santa Ana Army Air Base, Santa Ana.

Camp Haan, A.S.F. Regional Hospital, Riverside, Tuesday, June 5, at 1530

"Thoracic Surgery"—Dr. John Jones of Los Angeles, and Lt. Comdr. J. E. Dailey, U.S.N.H., Corona

Torney General Hospital, Palm Springs, Tuesday, June 5, at 1530

"Management of Simple Skin Diseases"—Lt. Col. E. R. Seale, MC, Chief Dermatologist, Santa Ana Army Air Base.

A.A.F. Regional Hospital, Santa Ana Army Air Base, Tuesday, June 5, at 1930

"Blood and Blood Substitutes"—Lt. Comdr. W. M. Cashman, U. S. Naval Hospital, San Diego.

Station Hospital, Camp Cooke, Lompoc, Wednesday, June 6, at 1300

"Internal Derangements of the Knee"—Dr. John C. Wilson, Professor Orthopedic Surgery, University Southern California, Los Angeles.

Huff General Hospital, Santa Barbara, Wednesday, June 6, at 2000

(To be Continued)

CALIFORNIA PHYSICIANS' SERVICE†

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C.P.S. From May, 1944, to May, 1945

Membership—May, 1944— 62 000.
May, 1945—140,000.
More than doubled membership.

Income from Members' Dues:

Now at the rate of $1,680,000 per year. (When rate change is fully in effect—July 1, 1945—with present membership, will be approximately $2,250,000.)

Unit value remained stationary throughout year at $2.25—90 per cent of par value—recent rate changes will achieve the long sought for 100 per cent.

Changes in Board of Trustees:

Dr. Ray Lyman Wilbur retired as president.

Dr. Lowell Goin, past president of C.M.A., elected to president of the Board at its meeting May 7, 1945.

Other additions to the Board are: Dr. Donald Lum of Alameda and Dr. J. Frank Doughty of San Joaquin County.

Reëlected: Dr. T. Henshaw Kelly of San Francisco.

Terms unexpired: Dr. A. E. Moore (San Diego), Dr. C. L. Mulfinger (Los Angeles), Dr. C. Glenn Curtis (Orange County), Dr. Chester Cooley (San Francisco), Dr. H. Randall Madeley (Solano County), Dr. P. K. Gilman (San Francisco) and Rt. Rev. Thomas J. O'Dwyer (Los Angeles).

This Board of Trustees appointed Mr. William M. Bowman, Executive Director, and Dr. A. E. Larsen, Medical Director.

C.P.S. is geared and ready to really take off this next year—the preliminaries are over—basic problems solved—now to cover more and more of the population.

* * *

(Ed. Note.—A report of the Board of Trustees of California Physicians' Service for the period May, 1944 to March, 1945, appeared in California and Western Medicine for April, 1945, pp. 223-225. T. Henshaw Kelly, M.D., Secretary of C.P.S., gave a supplementary report to the C.M.A. Council on May 7, 1945. Because of lack of space, it has been necessary to hold this supplement over for publication in the next issue of C. & W. M.)

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.
Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

American Medical Association. The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In June, KFAC will present these broadcasts on the following Saturdays: June 2, 9, 16, 23, and 30.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *This Book Hits Jack-pot:* Certain to join the great English physiological immortals is A. E. Barclay, K. J. Franklin and M. M. Prichard's Barcroftian classic, *The Foetal Circulation and Cardiovascular System, and the Changes That They Undergo at Birth*, 275 superbly illustrated pages extending careful work published in part in *British Journal of Radiology* (1940 plus), and developed with cineradiography, and of course delightfully written (Blackwell, Oxford, December, 1944, 50s, and available from C. C. Thomas of Springfield, Ill.). Get it!

2. *Other Books:* L. E. Napier offers 900 pages and 250 illustrations to *Principles and Practice of Tropical Medicine* (MacMillan, N. Y. 11, 1945, $12.50). For the alert surgeon there are C. R. Murray's *Surgery of the Motor Skeletal System*, G. Humphries' *Surgery of the Soft Tissues*, and C. Pilcher's *Neurosurgery* (Lippincott's, Philadelphia 5, 1945, $55). Morris Fishbein edits military hot-shots' *Doctors at War* (Dutton, N. Y., 1945, $5). Interesting is Schering Corp's *Sex Endocrinology* (Bloomfield, N. J., 1945, free). R. P. Parsons tells well of his naval hospital in the South Seas (*Mob 3*. Bobbs-Merrill, Indianapolis, 1945, $3.50). Worthy is J. R. Rees' *Shaping of Psychiatry by War* (Norton, N. Y. 11, 1945, $2.50).

3. *Books Climb Antibiotic Bandwagon:* S. A. Waksman properly leads with *Microbial Antagonisms and Antibiotic Substances* (Commonwealth Fund. N. Y., 1945, $3.75). W. E. Herrell takes good seat with *Penicillin and Other Antibiotic Agents* (Saunders, Philadelphia 5, 1945, $5). J. A. Kolmer climbs high with *Penicillin Therapy, Including Tyrothricin and Other Antibiotic Therapy* (Appleton-Century, N. Y. 1, 1945, $5). B. Sokoloff clings with unfinished *Story of Penicillin* (Ziff-Davis, N. Y., 1945, $2). And Winthrop offers more free brochures. So does Merck.

4. *More on the Antibiotic Bandwagon:* W. A. Randall & Co. describe method of estimating penicillin in body fluids (*Science*, 101:365, April 6, 1945), while A. Fleming, D. H. Heilman and W. E. Herrll discuss micro methods for same (*Am. J. Clin. Path.*, 15:1-7, 1945). W. G. Myers and H. J. Hanson induce new strains of penicillium by neutron bombardment (*Science*, 101:357, April 6, 1945). T. Hauschka & Co., in discussing mechanism of growth inhibition by hexenolactone, suggest antibiosis from reaction with SH groups essential in enzyme function (*Science*, 101:383, April 13, 1945). R. D. Muir and G. Valley suggest cysteine for sterility test for penicillin (*Ibid.*, p. 390).

5. *Chemotherapy:* C. Wilson, G. Higgins & Co. agree that 5 Gms. methionine daily has no beneficial effect in infective hepatitis (*Brit. Med. J.*, 1:399-401, March 24, 1945). O. Schales & Co. find 1, 4 dichlor, 2, 3 dihydroxy pehnazine indefinitely prevents growth of Staph. aureus in conc of 0.01 per cent (*Arch. Biochem.*, 6:329, 1945). B. V. Patel (Bombay), finds 2-N^1 sulfanilamide-5-ethylthiazol is highly effective with no toxicity in monkey malaria (*Quart. J. Pharm. and Pharmacol.*, 17:297, December, 1944). M. M. Cantor and J. W. Scott success-

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, San Francisco, now Dean of University of Texas Medical School.

fully treat agranulocytosis with IV pyridoxine, which is necessary maturation factor (*Canad. Med. Asso. J.*, 52: 368, 1945). W. Tadros (Cairo), describes estrogenic diethoxy-phenyl-bromethylenes which show antitumor action (*Nature*, 155:366, March 24, 1945). S. B. Ullman & Co. (Jerusalem), describe antitumor action of extracts of latex of Ficus carica (*Exp. Med. Surg.*, 3:11, 1945). A. Goth shows antibacterial properties of dicumarol (*Science*, 101:383, April 13, 1945).

6. *More:* P. M. Dawson and F. A. Hellebrandt continue their interesting study on aging influence on work capacity in PMD (*Am. J. Physiol.*, 143, 420, 1945). P. O. Gravelle beautifully illustrates the artistry of chemicals with polarized light on crystal growth (*Merck Rep.*, 54:12, April, 1945). Note proceedings Central Society for Clinical Research (*J. Lab. Clin. Med.*, 30:337-394, 1945). J. H. Lawrence & Co. describe "chokes," a respiratory manifestation of aeroembolism in high altitude flying (*Ann. Int. Med.*, 22:398, 1945). T. S. Cullen offers worthy tribute to Max Brodel (1870-1941), first director of Hopkins famed medical illustration institute (*Bull. Med. Lib. Asso.*, 33:5, 1945). E. V. Verkhovskaya confirms effective anesthesia with 2.5 cc. alcohol per Kg, in 50 per cent conc. in 5 per cent glucose (*Am. Rev. Soviet Med.*, 2:260, 1945). G. Antonoff discusses changes of properties of colloid mixtures with aging (*Arch. Biochem.*, 6:200, 1945). C. I. and B. P. Reed show that vitamin D exerts catalytic crystal orientation effect in bone (*Am. J. Physiol.*, 143:413, 1945). W. T. Liberton discusses time factors in electric convulsive therapy (*Yale J. Biol. Med.*, 17:571, 1945).

A Distinguished Man's Birthday.—Scores of Pasadena physicians and other citizens vied with one another in honoring Dr. George Dock on his recent birthday anniversary. This modest, gentle mannered man is widely recognized by the medical profession as one of the most distinguished American physicians.

For some forty years he was professor of the theory and practice of medicine in leading universities, among them, the University of Pennsylvania, University of Michigan, Tulane University, Washington University, University of Southern California.

He is author of several books, and has written numerous articles on medical subjects in journals and textbooks. Since 1896, when he first wrote on coronary thrombosis, he has been recognized as an authority on that deadly malady. He was a pioneer in the study and treatment of tropical diseases. For nearly twenty years, Dr. Dock has been in active practice in Pasadena as medical consultant.

One of the many charms of this scholarly scientist is the versatility of his mind and the breadth of his interests. He is a collector of rare books and a lover of flowers and birds.

In addition to several honorary academic degrees which have been conferred upon him, he received last year the highest award of the Association of American Physicians. The annual George Dock Lectureship on some phase of the history of medicine was established in his honor.

Sincerity, genial friendliness, genuine human interest combined with his scholarly habit and scientific achievement have richly earned for Dr. George Dock the title, "The Good Physician."—Pasadena *Star-News*, April 3.

Favorable Vitamin Reports Quickens Public Interest.—Public interest in vitamins has been quickened by recent research reports. Among such was the report made by Dr. Tom D. Spies, director of the Nutrition Clinic, Hillman Hospital, Birmingham, Ala., to the clinic's sponsor, the University of Cincinnati. He stated that in 1944 there had not been one death among 5,845 men, women and children treated in the clinic for deficiency diseases. More than 800 cured patients, he said have gone back to work, many in heavy industries, and 41 to the armed forces. Synthetic vitamins—thiamin, riboflavin, ascorbic acid and niacin—are prescribed at the clinic as supplements to normal eating habits.

Dr. Robert S. Harris, Associate Professor of Biochemistry of Nutrition, Massachusetts Institute of Technology, now reveals that upwards of 35 per cent of accepted nutritional values are lost through "bulk cooking" for miiltary consumption in barracks or aboard ships, or for civilians in hotels and restaurants.

"When you pick food for analysis off the fork, as it were," Dr. Harris told the Office of Pharmacal Information, "you find that between 30 and 50 per cent of the nutrients you might expect to find in it have been lost before they have reached the consumer's plate."

Gaining wide notice is Dr. Harris' so-called "Snatch Test." With associates of the Nutritional Biochemistry Laboratories of M. I. T. he subjected to chemical analysis three meals of each of 71 subjects. The meals were literally "snatched" from their plates to determine the thiamin, riboflavin, niacin, ascorbic acid, calcium and iron content. Adequacy of the diets was measured by comparison with the recommended dietary allowances of the Food and Nutrition Board, National Research Council. So measured, the average daily intake was found to be adequate in ascorbic acid, calcium and iron, but inadequate in thiamin, riboflavin and niacin. Only 7 per cent of the subjects obtained an adequate intake of all these nutrients. Only 35 per cent received the minimum daily requirement of the Food and Drug Administration in thiamin, riboflavin, ascorbic acid, calcium, and iron.

Public Health League Legislative Report

(Following report is continued from page 320)

MASSAGE

Assembly Bill 395—Establishing Massage Board—defeated in committee.

NATUROPATHY

Senate Bill 160—Establishing Naturopathic Board—passed out of Senate Committee without recommendation and defeated in Senate by vote of 25 to 7.

Assembly Bill 1909—Establishing Naturopathic Board—still in committee.

NURSING

Assembly Bill 379—Extending emergency exemption—passed Legislature and signed by the Governor.

Assembly Bill 1235—Abolishing the 21-year age requirement—passed Assembly and now in Senate committee.

SALES TAX

Assembly Bill 712—Exempting appliances and restorations—passed the Assembly and now in Senate committee.

Wisconsin Group Denies 'Improper Practice' Charge.—Ward Ross, general manager and counsel for the Wisconsin Alumni Research Foundation, declared on May 15 that "We disagree with the government on the charge that the foundation has been guilty of any improper practices.

"In reference to the government's charge of maintaining high prices, today Vitamin D, on the basis of the human requirements for it, is the cheapest of the known vitamins," he declared.

Ross said, "The matter is in litigation now, and comes up in Chicago this fall." He referred to Government charges of monopoly and price fixing of vitamin D products filed in Federal Court here against the foundation, 17 manufacturing firms and one individual.

Postwar Jobs in Medical Occupations.—Students, teachers, parents and others interested in medical occupations will find helpful information in three new six-page Occupational Abstracts on Medicine, Nursing, and Medical Laboratory Technologist, just published by Occupational Index, Inc., New York University, New York 3, N. Y. at 25 cents each, or 75 cents for the three.

Each abstract covers the nautre of the work, abilities and preparation required, entrance and advancement, earnings, number and distribution of workers, postwar prospects, advantages and disadvantages and sources of further information, including a select bibliography of the five best references.

DDT Products Loom Big For Post-War Households.—Development of DDT products for general household use as repellent of mosquitoes, flies and other pestiferous insects is viewed as an immediate post-war trend in the packaged medicine field by Dr. E. C. Merrill of the United Drug Company, Boston.

"Expansion of the insecticide field will be most important as a health factor," Dr. Merrill told the Office of Pharmacal Information. "From the world point of view of lives saved, the widespread public use of various combinations of dichloro-diphenyl-trichlorethane (DDT) will rival penicillin."

DDT is being released to industrial laboratories for experimental research. Dusting powders and sprays are most likely developments for home purposes. DDT is a potent drug and like many others its preparation and wholesale use requires considerable technical skill.

Latest release from the U. S. Department of Agriculture reporting results of two years tests with this chemical agent against more than 70 different species of insects showed it experimentally to be definitely more effective than those currently used for control of some 30 pests. Among the insects on which the tests were made were mosquitoes, bedbugs, three kinds of lice on man, and houseflies and fleas in buildings.

American College of Chest Physicians.—The Board of Examiners of the American College of Chest Physicians announce that the next written examination for Fellowship will be held at Chicago, June 6th. Candidates for Fellowship in the College who plan on taking the examination should contact the Executive Secretary of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:..

California Physicians' Service

San Francsico.—(U.P.)—The State Supreme Court today granted a hearing to Maynard Garrison, state insurance commissioner, who has made a three-year fight to have the California Physicians' Service placed under the commission's jurisdiction.

The State-wide service includes 5,000 physicians and members whose monthly dues cover any necessary medical care. The doctors' fees are paid from the Association's funds.

Garrison has held that the payment of dues in return for medical service is an insurance action and should be supervised by the commission.—Santa Maria *Times*, April 12.

More Doctors

Chicago, May 22.—The number of physicians in the United States increased by 3,306 in 1944, the American Medical Association reports. Many more than this number, however, were added to the armed forces as medical officers during the year, so there was a decrease in 1944 of the number of doctors available to civilians.

There were 6,933 additions to the medical profession in 1944. These were the men and women who in that year received their first license to practice medicine and surgery. During the same year 3,627 physicians died.—San Francisco *News*, May 22.

Industrial Physicians' Association

Los Angeles, May 7.—(A.P.)—Dr. Richard O. Schofield of Sacramento has been elected president of the Western Association of Industrial Physicians and Surgeons, succeeding Dr. Rutherford T. Johnstone, Los Angeles.

Other officers chosen are Drs. John D. Ball, Santa Ana, Calif., vice president; Rodney R. Beard, San Francisco, secretary; J. M. McCullough, Crockett, treasurer, and Benjamen M. Frees, Los Angeles, Robert T. Legge, Berkeley, William P. Shepard, San Francisco, and A. C. Dick, San Diego, directors.—Sacramento *Bee*, May 7.

A.M.A. Journal Assails Veterans' Medical Care

Chicago, March 28 (A.P.)—Declaring that medical care for veterans appears "especially poor" compared with that in the armed forces, the *Journal of the American Medical Association* today suggested an independent investigation by a committee reporting directly to President Roosevelt.

"A continuous flow of charges comes from a variety of investigators, commentators, periodicals and publications whose observations have led them to believe that medical care in the Veterans' Administration is on a standard far lower than that prevailing in ordinary practice in the United States," the *Journal* said in an editorial.

"The deteriorated service seems especially poor when contrasted with the high quality of medical care rendered to those in the armed forces."

The *Journal* reviewed reports made by the U. S. Senate's subcommittee on wartime health and education and by newspapers and magazines and said:

"Perhaps the time is ripe for a really authoritative, independent investigation of the administration of medical service to veterans, made by a committee responsible directly to the Executive Office of the President."

The *Journal* reported that the charge has been made that the chief administrator of the Veterans' Administration has "little sympathy with a high quality of medical service" and commented:

"Although the administrator has full authority and adequate funds to avail himself of the very highest quality of consultation and part time services of leading physicians, the utilization has been minimal."

The editorial said veterans' hospitals are not accredited by the A.M.A. Council on medical education and hospitals as institutions suitable to the training of interns, by the council's standard.

"The proper development of the hospitals for veterans would lead, no doubt, in the future toward the utilization of veterans' hospitals for this purpose; this in itself would tend to raise greatly the standard of medical care," the *Journal* concluded.—San Francisco *Chronicle*, March 29.

Debt to Society

The well-worn phrase about "paying a debt to society" takes on new meaning in the case of the several hundred inmates of three prisons who have volunteered as "guinea pigs" in testing new drugs to combat malaria.

Their volunteer duty will extend beyond that of the soldiers who bared their arms to the anopheles mosquito in Walter Reed's search for the malaria carrier. For these men will not only contract the disease, but will submit to experiments with potential remedies whose properties and correct dosage are as yet imperfectly known.

If the tests are successful, malaria sufferers have promise not of the relief and control that quinine and atabrine bring, but of complete cure of this recurring disease. Most important, success will provide a remedy for thousands of soldiers who have contracted this painful, exhausting and sometimes fatal disease.

It is significant that these prisoners are promised nothing beyond the best of care. They are offered no special privileges, commutation of sentence, or other reward. They are simply in the best and truest sense paying their debt to society.—San Jose *Mercury Herald*, May 9.

Six Steps for the Future

Surgeon General Parran recently outlined six steps which must be taken to create a comprehensive national health program: (1) development of a financial scheme through insurance, tax funds or both, to pay costs of medical care for all, (2) grants-in-aid to states for construction of hospitals and health centers, (3) more educa-

tional facilities to train doctors, nurses, technicians to meet the expanded demand, (4) full-time health departments for every part of the country, with full programs of preventive activities, (5) continued support of public and private medical research, (6) provision of adequate water supply and sewerage systems for all.—Maternity Center Association *"Briefs."*

Proposed Change in California Adoption Laws

California law gives an unwed mother sole custody of her child, and the right to give it for adoption without notice to the father.

An amendment has passed the Assembly, and is in the Senate, to extend this right to a married woman who says that her husband is not the father of her child. She could then give the child for adoption without notice to the husband.

We believe this is a dangerous measure. An unwed mother owes responsibility to the child only, not to the father. But a married woman owes responsibility to her husband. Evidence of illegitimacy she might offer could be falsified more readily if the husband had no notice to contest the proceedings. Also, he has a right to know.

The measure does not mention servicemen overseas, but the times and the arguments urged for the proposal do imply that the purpose is to protect the peace of mind of fighting men against knowledge of wives' infidelity. The Army paper *Stars and Stripes* properly is indignant. We believe the measure is unwarranted meddling in personal affairs, whether the busband is a serviceman or a civilian away on a business trip.—Editorial in San Francisco *Chronicle,* June 7.

"Fatherless" Baby Bill Blasted by Army Paper

London, June 4.—(A.P.)—A bill pending before the California Legislature which would permit a faithless wife to arrange for the adoption of an illegitimate child, without notifying her husband, brought today from *Stars and Stripes* the editorial comment, "Well, we'll be damned."

"We thought professional handholders, social thinkers and screwball intellectuals who have been making capital of 'veterans' problems' had already gone far enough," the Army newspaper said, "but when a responsible legislative assembly passes a bill which denies a husband the right to know that his wife has just come up with some one else's baby, we think the whole situation is getting out of hand."

(The bill was passed by the California Lower House Saturday and is now before the Senate.)

"No sensible person will condone infidelity in the marriage partnership. Out of the millions of separated husbands and wives of World War II the majority are playing the game straight.

"Most of them, when they resume normal living, can look each other clearly in the eye without apology and go about the business of reweaving the fabric of their lives.

"Some, of course, will practice deceit. Others may make a clean breast of interim unfaithfulness. In either case it's a problem between a man and his wife and nobody else's business.

"But by all that's holy, let's not have a sovereign state joining in a lie as definite and indisputable as another man's baby.

"We may need handholding by the experts, but we don't need it that bad."

The editorial characterized the bill as "another indication of the growing tendency among a certain type of thinker to make of the overseas veteran a peculiar social problem who must be spared the realities and hand processed back into civil life upon his return."—San Francsico *Examiner,* June 5.

Loose Statements on Nation's Health Condemned by J.A.M.A.

Urges Better Scientific Evaluation of Facts Relating to Proposed Changes in Methods of Medical Practice

The use of propagandists of incomplete statements regarding various aspects of the nation's health in support of proposed changes in methods of medical practice is condemned by *The Journal of the American Medical Association* for April 28. The *Journal* says:

"Among the major annoyances to American physicians of the last decade have been the loose statements emanating from propagandists in support of proposed changes in methods of medical practice. The death rates in the United States, although they are among the lowest if not the lowest of any great nation in the world, are always described as 'shocking' or 'amazing.' We are told again and again that one-third or more of American youths are physically unfit, but they never say physically unfit for what or by what standard. This type of viewing with alarm has now aroused the satire of a writer for the New York *Times.* He says in a recent issue that there is one indispensable rule for viewing with alarm and that is, when quoting, never to use conditional or supplementary clauses. His first example is a statement recently syndicated under a Washington date line: 'Only one American in a thousand is really well fed.' Now actually Americans are today about the best fed people in the world. This does not mean to say that the modern advances in the science of nutrition are universally applied. That will no doubt involve a long process of education. No one has yet discovered a technique for overcoming completely the cultural lag between the acquisition of knowledge and its extension to the remotest individual in the population. The truth about nutrition is expressed in the following, which is the whole sentence: 'Only one American in a thousand is really well fed, in the sense that no further improvement in his physical condition could be made by changes in his diet.'

"Innumerable Americans have been startled in the last three years by the amazing misuse of the statistics coming from the Selective Service System and repeatedly quoted by writers in the press and in the reports of various governmental committees. Even Senator Pepper's Interim Report of the Committee on Education and Labor of the U. S. Senate emphasized the statistics although they did use also the saving statement that we are not obviously a nation of weaklings. The writer for the New York *Times* calls attention to the statement 'Only one American in ten thousand can really be said to boast of a proper physique.' This is a startling indictment, but the sentence, to be finished honestly, must include the clause 'taking the Apollo Belvedere as a standard.' Scientific writers have emphasized again and again that the examination of millions of young men was conducted for a specific purpose—to obtain an army. Moreover, the standards of induction varied from time to time, beginning with an exceedingly high standard when we were concerned with the raising of an army of a million men for training and proceeding to a somewhat lower standard, involving the acceptance of men with manifest disabilities, when it became necessary to scrape the bottom of the barrel. Under the heading 'The Nation's Health' the New York *Times* commentator says:

That second example of what we may call the missing conditional clause is no doubt considerably exaggerated. But in kind if not in degree it is in the same class with so many statements about the positively frightening percentage of American school children who suffer from physical defects, said "defects" often consisting of troublesome tonsils or a couple of tooth cavities or three pounds under weight. It applies, though in less degree, to the large percentage of men disqualified for military service, where the emphasis on "military" is slighted and then entirely forgotten. We end up by speaking of the American nation as 25 per cent physically unfit.

"Similarly we must analyze more scientifically all of the figures now being developed relating to what are called neuropsychiatric disabilities or defects. Many experts are convinced that a large percentage of those who are classified neuropsychiatric under military conditions are able to live efficient, satisfactory lives as civilians in the occupations to which they are adapted. A psychologist has pointed out that the age of 16 years is taken as a maximum for mental sufficiency, so that we need not be alarmed if we are called a nation of 14 years old or 12 year old mentalities. If Thomas Jefferson and Winston Churchill are classified as 16's, the rest of us can be reasonably satisfied to be called 14's.

"Not every one is capable of evaluating scientifically the startling statements made by those who would strike fear as part of a propaganda to secure change. Quoting again:

. . . It is dynamic to say that Americans are really not well fed, if the plain duty of nutrition is to turn us all into Discus Throwers and Venus de Milos, into Johnny Weissmullers and Babe Diedricksens.

The usual retort is that in order to get people to do things you must throw a scare into them. And yet President Roosevelt said that the only thing we have to fear is fear itself."

Bring me men to match my mountains,
Bring me men to match my plains,
Men with empires in their purpose,
And new eras in their brains.

—Sam Walter Foss, *The Coming American.*

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Vasectomy and Salpingectomy Under California Law*

In recent years there has been considerable discussion pro and con, with respect to sterilization of humans. Sterilization involves social, economic, and legal problems with all of which physicians are vitally concerned. In this article we shall limit ourselves to a discussion of the legal aspects of sterilization, particularly emphasizing the duty and privileges of physicians.

It must be understood that we are not approaching the problem of human sterilization from a social point of view; that is to say, we are neither advocating sterilization nor opposing it; we are neither endeavoring to point out how it can be done with legal safety, nor are we endeavoring to discourage sterilization operations by erecting or magnifying legal obstacles. On the contrary, we shall merely endeavor to analyze those rules of law which, in our opinion, are applicable and that govern physicians who undertake to determine whether or not a particular person should be sterilized.

Any discussion of the legal status of sterilization must be divided into: first, compulsory sterilization by state agencies; and, second, voluntary sterilization by private physicians. In turn, the second division should be subdivided into: first, the criminal law as applied to sterilization; and, second, the civil liability, if any, arising out of sterilization.

I. Compulsory Sterilization by the State

Status of Compulsory Sterilization.—California has become the leading state in development and application of the policy of sterilizing unfit persons. Of some eight or nine thousand compulsory sterilizations performed in this country up to 1938, approximately six thousand occurred in this state. These numbers have without doubt increased several thousand since 1938.

The California statutes under which these sterilizations have been performed are:

Section 6624 of the Welfare and Institutions Code, which provides:

> The provisions of this section apply to any person who has been lawfully committed to any state hospital, and who is afflicted with, or suffers from, any of the following conditions:
>
> (*a*) Mental disease which may have been inherited and is likely to be transmitted to descendants.
>
> (*b*) Feeble-mindedness, in any of its various grades.
>
> (c) Perversion or marked departures from normal mentality.
>
> (*d*) Disease of a syphilitic nature.
>
> Before any such person is released or discharged from a state hospital, the State Department of Institutions may, in its discretion, cause such person to be sterilized. Such sterilization, whether performed with or without the consent of the patient, shall be lawful and shall not render the department, its officers or employees, or any person participating in the operation liable either civilly or criminally.

and Penal Code, Section 645, which states that:

> Whenever any person shall be adjudged guilty of carnal abuse of a female person under the age of ten years, the Court may, in addition to such other punishment or confinement as may be imposed, direct an operation to be performed upon such person for the prevention of procreation.

and Deering's General Laws, Act 539, which provides that whenever the resident physician of the state prison deems it to be beneficial to the physical, mental, or moral condition of any recidivist lawfully confined in such prison to be asexualized, such physician shall consult with the general superintendent of state hospitals, and the secretary of the State Board of Health, and after a joint examination into the particulars of the case the three may direct the operation to be performed. However, such operation cannot be performed unless the recidivist has been committed to a state prison at least twice for rape, seduction, etc., and has given evidence that he is a moral and sexual degenerate. The Act also provides that any minor idiot may be asexualized under the direction of the medical superintendent of any state hospital with the written consent of the parents or guardian.

Nineteen states have some statutory regulation of sterilization. The objective of eleven of these is both eugenic and therapeutic, of six purely eugenic, and of two eugenic, therapeutic and penal. Seven statutes provide both for voluntary and compulsory sterilization, seven for compulsory sterilization only, and five for voluntary sterilization only. Three-fourths of the operations throughout the country have been on the insane, one-fourth on the feeble-minded; and of the total, more than one-half have been on males.

With respect to those persons who are within the foregoing statutes (*i. e.*, feeble-minded, perverted or syphilitic persons, recidivists, rapists, and persons with inherited mental diseases), sterilization by a state agency is lawful.

II. Sterilization Outside of State Institutions

Therapeutic Sterilization.—In California there is no statute expressly granting or denying the right to perform or have performed a sterilization operation outside of state innstitutions. However, it would seem reasonable to conclude that, at least in so far as therapeutic sterilization is concerned, it can be performed legally under some conditions even in the absence of express permission of law. The scope of those conditions can only be ascertained or surmised by drawing analogies to similar laws. It is quite likely that the rules relating to abortions would govern since the avowed purpose to be accomplished is similar even though there is no "taking of a life" in sterilization operations. In relation to abortion, the Penal Code of California, Section 274, provides:

> Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug or substance, or uses or employs any instrument or other means whatever with intent thereby to procure the miscarriage of such woman, *unless the same is necessary to presreve her life,* is punishable by imprisonment in the state prison not less than two no more than five years.

In abortion cases it is necessary that the physician determine for himself that the patient's life will be endangered by pregnancy. There are no guide-posts to assist the physician in this determination and, therefore, as a protection to himself, consultation and approval of one or more other physicians should be obtained. Whenever this care has been taken, the physician may feel fairly certain as to his immunity. There is no case on record in which a physician has been held responsible criminally or civilly under such circumstances. As to the exact illness or condition that must be present, no suggestion can be offered, except that any physical condition which would endanger the mother's chances of surviving childbirth is undoubtedly sufficient ground for the operation. In the light of this, it can be said that sterilization of the female may properly be performed under like circumstances.

As to the male, the situation is more difficult. In *Christensen* vs. *Thornby*, 255 N. W. 620, Minn. 1934, the facts were as follows: A vasectomy had been performed upon a male because his wife's life would have been endangered by pregnancy. Thereafter, the physician was sued for damages on the ground that he had advised the plaintiff

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

* This article, by request, is reprinted from CALIFORNIA AND WESTERN MEDICINE, May and June, 1941.

that the vasectomy had been successful and guaranteed sterility. Some time following the operation, however, the plaintiff's wife became pregnant and plaintiff, because of his wife's condition of health which would render childbirth dangerous, experienced anxiety and was subjected to considerable expense before and after the birth of the child. The Court, in rendering a decision in favor of the defendant physician, stated that there was nothing immoral about such an operation since most states permit the same upon the female to protect her life, and that there is no reason why the husband should not be permitted to submit to a vasectomy to protect his wife since there is much less danger involved in that operation than in a salpingectomy. The Court stated that the argument that the husband might later marry some other woman and be incapable of progeny is not sufficient to render the operation immoral. The Court stated:

Therefore, in our opinion, it was entirely justifiable for them to take the simpler and less dangerous alternative and have the husband sterilized. Such an operation does not impair, but frequently improves, the health and vigor of the patient. Except for his inability to have children, he is in every respect as capable physically and mentally as before. It does not render the patient impotent or unable "to fight for the king" as was the case in mayhem or maiming. Liability of Physicians for Sterilization Operations, Am. Bar Assn. Jour., Vol. 16 (1930), p. 158. See *Smith* vs. *Wayne Probate Judge,* 231 Mich. 409, 417, 204 N. W. 140, 142, 143. We, therefore, hold that under the circumstances of this case the contract to perform sterilization was not void as against public policy, nor was the performance of the operation illegal on that account.

(To be concluded.)

LETTERS†

Concerning Malpractice Liability Through Volunteer Nurses' Aides:

EMERGENCY MEDICAL SERVICE
411 Phelan Building, 760 Market Street
San Francisco 2, California

November 29, 1944.

Mr. Wm. Yount, Deputy Director,
Southern Area, California State War Council,
Room 627, State Building,
Los Angeles, California.

Dear Mr. Yount:

Enclosed is a copy of an opinion voluntarily rendered to me by Hartley F. Peart, Esquire, General Counsel, California Medical Association, on the liability of Volunteer Nurses' Aides to suits for malpractice.

Dr. Halverson has signed a letter requesting an opinion on the same question of the State Attorney General.

When information from the Attorney General has been received here, I shall forward a copy of it to you.

Sincerely,

(Signed) MORTON R. GIBBONS, M.D.,
Chief, Emergency Medical Service.

* * *

San Francisco 4, November 25, 1944.

California State War Council,
Emergency Medical Service, addressed.

Attention: Morton R. Gibbons, M.D., Chief, Emergency Medical Service.

Dear Doctor:

I have examined your letter of November 24, with enclosed copy of Dr. Halverson's request to the Attorney General for an opinion.

I believe that volunteer nurses' aides could be subjected to liability in a malpractice action, even though their services are purely voluntary and gratuitous. In so far as the voluntary aspect of their services is concerned, they would be in the same position as a physician donating his services to county hospitals or charitable institutions. Such a physician is subject to malpractice actions to the same extent as a private physician offering his services for a fee.

The fact that a nurses' aide does not have the same training and experience that a registered nurse has would undoubtedly lower the standard of care which she would be required to fulfill. In my opinion, however, it would be possible to hold a nurses' aide liable for damages resulting from a departure by her from the standard of care normally exercised by other nurses' aides or persons having similar training and qualifications in the community. Of course, a nurses' aide would not be held to the same standard of care as a registered nurse, and if she acted under direct instructions from a registered nurse or a licensed physician, I do not believe that any court would hold her responsible for the results of her actions.

I know of no provision in the War Powers Act or the War Civilian Security Program to meet this danger.

Yours very truly,

(Signed) HARTLEY F. PEART.

Concerning Literature to Military Camps:

STATION HOSPITAL
OFFICE OF THE SURGEON
MUROC ARMY AIR FIELD
Muroc, California

My dear Doctor:

Your recent letter offering to send medical literature to this station has been read with unusual interest and has been posted on the bulletin board for the information of all Medical Officers on duty here.

Your periodicals will be a valuable addition to the professional library of this hospital.

Please convey our grateful appreciation to the members of your Association.

Most sincerely,

(Signed) ROGER S. THOMPSON,
Lt. Colonel, MC,
Surgeon.

* * *

ARMY SERVICE FORCES
NINTH SERVICE COMMAND
Headquarters Camp Beale, California

Dear Dr. Kress:

This letter will acknowledge the receipt of the medical journals and books which were sent to this hospital recently by the C.M.A. Postgraduate Committee.

We appreciate your effort in sending this material to us and feel sure that the medical officers in the different Commands will profit by the receipt of this literature.

We have a fairly complete library at this hospital so far as current medical journals are concerned. However, we are short of medical books, particularly on diseases of women. Now that we have the WACs with us, we find that our problems along this line are increasing and reference books dealing with gynecological problems would be very acceptable.

Thanking you for your interest, I am,

Fraternally yours,

(Signed) OLIN PAUL,
Major, MC,
Chief of Medical Branch.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 6, June, 1920

EXCERPTS FROM EDITORIAL NOTES

The Santa Barbara Meeting.—Nearly six hundred in attendance, wonderful weather, an uncommon feeling of fellowship and of union in a common cause, these were among the factors which made the 47th annual session of the Medical Society of the State of California, at Santa Barbara, May 11-13, 1920, the best and the most fruitful in the history of the Society. The program was unusually strong. The absence of long discursive papers, the snappy, short addresses by men who knew their subjects, all contributed to unusual scientific value. Dr. John H. Graves of San Francisco was elected president-elect, Dr. John C. Yates of San Diego assumed the office of president, Dr. William Duffield of Los Angeles was elected first vice-president, Dr. Joseph Catton of San Francisco was elected second vice-president, and Dr. Saxton T. Pope of San Francisco was reëlected secretary. It was decided that the session of 1921 should be held in San Diego. . . .

New Minimum Fees for Industrial Accident Work.—At the meeting of the House of Delegates May 11th, at Santa Barbara, the report of the Committee of the Council on Industrial Accident Work was adopted Full report of the committee will be published in the July issue of the JOURNAL.

This is the result of a prolonged effort on the part of the Council to get more equitable fees for Industrial Accident cases. The State Society has never gone on record as accepting any fee schedule in this sort of work, and it is well recognized that the remuneration heretofore offered has been entirely inadequate. We have now officially accepted the standard of fees which have been agreed to by the Industrial Accident Commission and the carriers throughout the state. This is not a final adjustment. It is but the beginning of a graduated scale of compensation for surgical services, and it will be changed from time to time as conditions warrant. It is, however, a start in the right direction. . . .

"Better Health."—At last the long-looked-for day has arrived when the medical profession has available a medium for direct interpretation to the public, in readable, understandable form, of the facts and results of modern scientific medicine. What doctor has not lamented the lack of such a medium? What doctor but has wished time and time again for some way in which medical lore and scientific data could be carried accurately and with authority to the public? "Better Health" supplies this need. . . .

It is the organ of the League for the Conservation of Public Health, and its editor is Mr. Celestine J. Sullivan, the executive secretary of that organization. The League is here to stay. It has demonstrated its worth. It is very much alive. *It is in the fight.* It will win the fight. What fight? The only fight in which the doctor as a doctor is vitally interested. The fight for better and best health for every member of the body politic of these United States, starting in our own California. . . .

(Continued on Front Advertising Section, on Page 20)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners will be held at Native Sons Hall, 414-430 Mason Street, San Francisco, from July 9th to 12th, 1945.

At this meeting legal hearings will be held in cases where licentiates of the Board have been cited to show cause why their California license should not be revoked for violation of one or more of the sections of the Business and Professions Code.

Petitions for modification of terms of probation, heretofore imposed, as well as for restoration of revoked certificates, will be considered during this meeting.

Written examinations for all classes of candidates licensed by the Board of Medical Examiners will be held, starting Tuesday, July 10th and continuing through Thursday, July 12th.

The next oral examination now scheduled will be conducted on August 11th at the Board office, Room 907 State Building, Los Angeles.

News

"Sheriff Ben J. Richardson said today Dr. Wesley L. Ricker, 43, Fresno, had been released on $1,000 bail after Richardson arrested him in Weed, May 10th, on a charge of practicing medicine without a license. Ricker, who is said to maintain a home office in Fresno, has made periodic, advertised trips to this county over a period of many months." (Press dispatch dated Yreka, May 12th, published in Sacramento *Bee*, May 12, 1945.)

"The California Board of Medical Examiners announced today 147 out of 152 applicants passed the examination for physicians and surgeons held Feb. 28 to March 2 in Los Angeles. The highest mark was made by Stanwood Schmidt, Berkeley, who scored 90-1/9 per cent." (Press dispatch dated Sacramento, May 15, published in San Francisco *News*, May 15, 1945.

Report from the Investigation Department discloses that on May 10, 1945, Anastasia Velasquez, unlicensed midwife, was arrested for practicing midwifery in Kern County without a license. The report stated that she was found guilty by Justice of the Peace L. E. Pryor, who imposed a fine of $100 and sentenced her to 90 days in the county jail, suspending the jail sentence for two years, on condition she refrain from delivering any more babies or giving any other type of treatment.

Report from our Investigation Department discloses the investigation and arrest of an individual using the name of Patrick Michael O'Hara, who was alleged to have violated Section 2141 of the Business and Professions Code. This man was said to have masqueraded as an officer in the United States Navy. Upon questioning by investigators, he first claimed graduation from Tulane University Medical School, New Orleans, La., but later admitted that he had not attended any medical school.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

pollen bombardment

GONE are the days when hay fever victims piled the family into the car at the first sneeze—and headed for pollen-free areas.

This year the majority of the estimated 3,000,000 hay fever sufferers will have to "sit tight and take it" when the pollen bombardment gets under way.

Amodrine

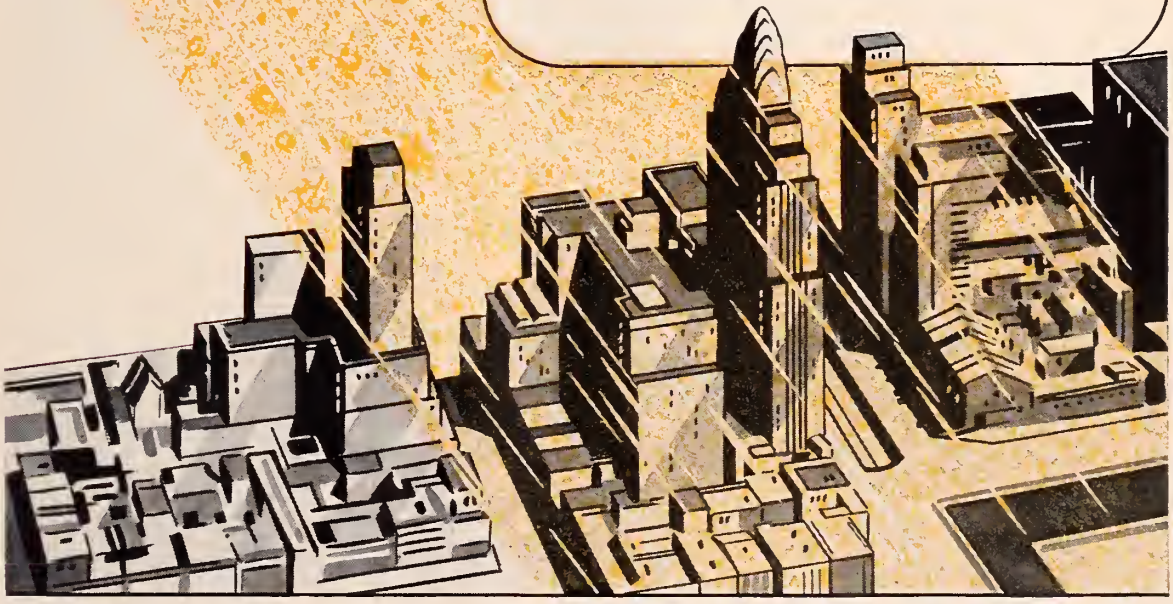
combining the sedative effect of PHENOBARBITAL 8 mg. (⅛ gr.) and the vasoconstrictor activity of RACEPHEDRINE HYDROCHLORIDE 25 mg. (⅜ gr.) with the well known antiasthmatic value of AMINOPHYLLIN-Searle 100 mgs. (1½ grs.)—rationally and effectively controls the symptoms of bronchial asthma and hay fever, with an absolute minimum of side reactions.

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Because DRYCO assures adequate protein intake with minimal gastro-intestinal upsets from fat indigestion...and because of its optimum mineral and vitamin content, physicians depend on DRYCO for normal as well as "special" infant feeding cases.



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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

cases, twenty-five whites with one pneumonia and death; 60 Indian with five pneumonias and five deaths. I stepped into one Indian shack without a mask and found sixteen cases bunked around on the floor of the same room, all coughing and spitting on the floor. I stepped out and put on a good thick gauze mask and then waded into them. . . .

Feb. 9. Call to ancient abandoned county seat to ease the itch of a case of chronic eczema. . . .

Feb. 21. Primipara—8-pound boy, complete breech. Had husband put her to sleep, did a version maneuver, brought down the feet and did an extraction. All O.K. and every one happy! . . .

March 23. Mexican breed came in for cough medicine for six months' old baby. Later he called me when I was out—when I got back found the baby dead,—gastro-enteritis. I unwisely salvaged my cough medicine, which had not been paid for. Later the "breed" spread the story about that I killed his baby with the wrong medicine, which was so hot that a drop spilled on the floor burned a hole in the wood. Three months later I had my comeback when the "breed" had a runaway and smashed up himself and whole family. Before I would touch any of them I made him eat the former malignant story. He has been a "good Indian" ever since. . . .

Excerpt from Obituary:—There died at Livermore on March 9th Dr. Emile Schmoll, one of the ablest physicians that California has seen. He was born at Basel, Switzerland, in 1873, of Alsatian parents, who emigrated after the War of 1870. After getting his medical training in Basel and Strasburg, he had the good fortune to become an assistant of Naunyn, one of Germany's greatest physicians and a pioneer in the study of metabolism.

(Continued on Page 40)

How Long is a good night's sleep?



Four? Eight? Sixteen hours? Eight hours most closely approximate the requirements for normal physiological recuperation. Ipral functions within this range. Given one hour before retiring, Ipral will carry the patient through a full night's sleep, unlike the shorter-acting hypnotics whose effects wear off quickly. Ipral will then permit the patient to wake up in the morning generally calm and refreshed; free from the lassitude of longer-acting hypnotics. Ipral Calcium (calcium ethylisopropyl barbiturate Squibb) in 2-grain unidentifiable tablets.

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Long Beach: Thackray's Prescription Pharmacy
Los Angeles: All Horton & Converse Prescription Pharmacies
Exclusive Prescription Pharmacy
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Modesto: Thorne's Prescription Pharmacy
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Sacramento: Pucci's Professional Pharmacy
Salinas: Holaday's Pharmacy
San Francisco: Lane Prescription Pharmacy, 809 Flood Bldg.
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TWENTY-FIVE YEARS AGO

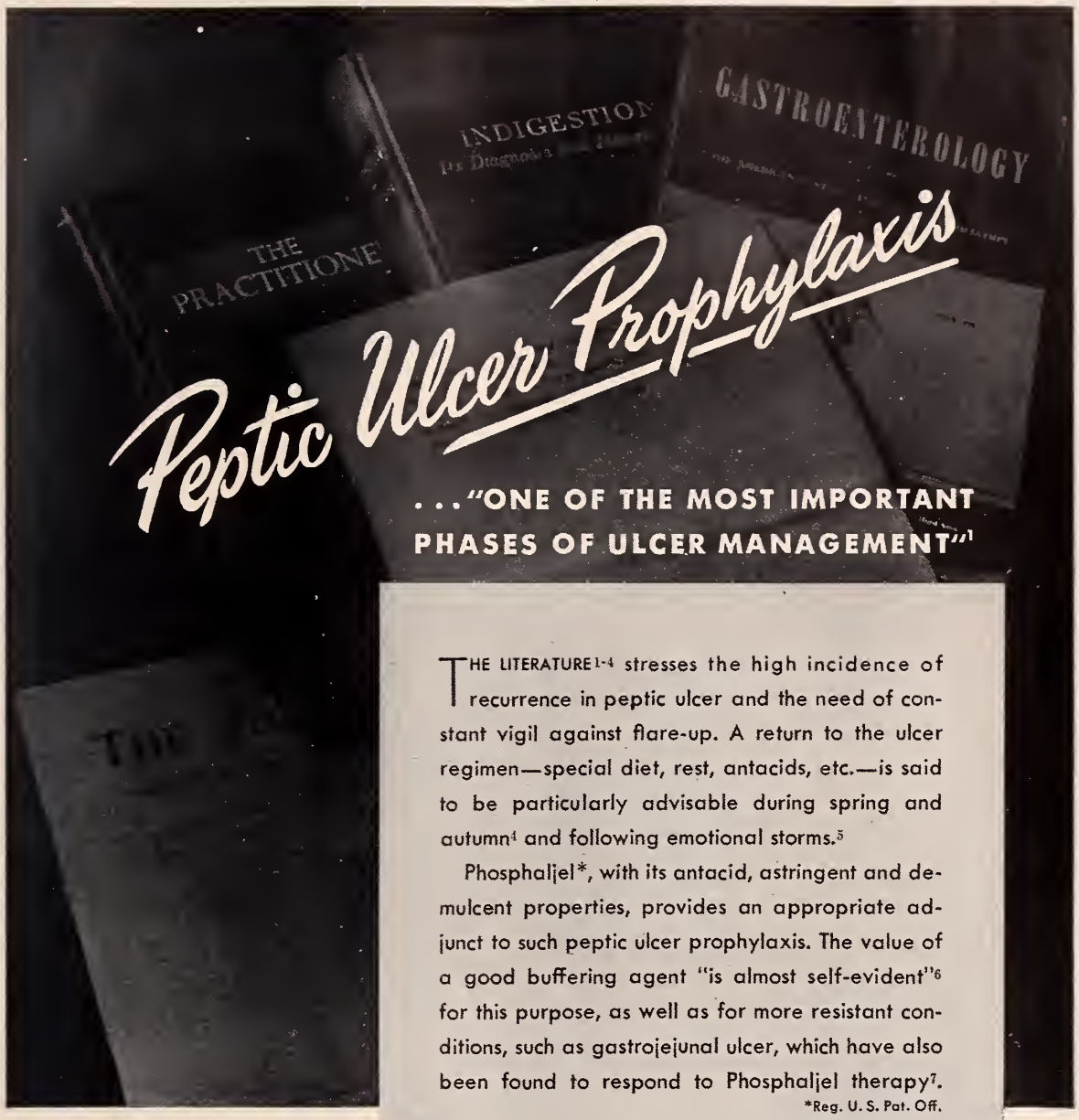
(Continued from Page 36)

. . . He moved to San Francisco in 1904 and went to work in the Cooper wards at the City Hospital. It was while working there that he was arrested by the late Dudley Tait for practicing without a license. It was characteristic of Schmoll's bigness of heart that when he realized that this arrest was due purely to the excess of Tait's zeal in a good cause, he promptly forgave him and afterward counted him among his best friends.

About 1908, he was very much discouraged over his inability to get a practice and was planning to leave, when things suddenly began to come his way. From that time onwards, patients flocked to him in ever increasing numbers until he had one of the best clienteles in the city. As this sudden rise to fortune has been an inexplicable puzzle to many of his confreres, it might be of interest to analyze some of the factors which contributed to his success. There may have been at first one little factor of luck. Out at the City Hospital in 1905 was an interesting old Irishman, badly crippled with the gout. When Schmoll got him back on his feet, this man in gratitude hurried to see his old employer, one of San Francisco's millionaires, who was also suffering with gout. Soon the millionaire got relief, and it was not long before all the sore feet in the Pacific Union Club were hobbling toward the door of an obscure physician on Sutter Street. . .

His great success was due in large part to the fact that he prepared thoroughly before he began private practice. He knew well the basic sciences; he thought about his clinical problems in terms of deranged physiology; and his wide reading kept him ahead of his time. . . .

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THE LITERATURE[1-4] stresses the high incidence of recurrence in peptic ulcer and the need of constant vigil against flare-up. A return to the ulcer regimen—special diet, rest, antacids, etc.—is said to be particularly advisable during spring and autumn[4] and following emotional storms.[5]

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1. Backus, H. L.; Gastro-Enterology **1**:471, 1943, W. B. Saunders Co., Phila. 2. Hurst, A.: Practitioner **152**:193, 1944. 3. Berk, J. E.: J. Med. Sac. N. J. **41**:365-370, 1944. 4. Rehfuss, M. E.: Indigestion, Its Diagnosis and Management, Phila. W. B. Saunders Co., 1943, pp. 241-243., 5. Alvarez, W. C.: Gastraenteralogy, **2**:65-67, 1944. 6. Selye, H. and MacLean A.: Amer. J. Dig. Dis. **11**:319-322, 1944. 7. Fauley, G. B., *et al.*: Arch. Int. Med. 67:563-578, 1941.

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There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

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MAGNESIA	339.3 parts per million
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SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
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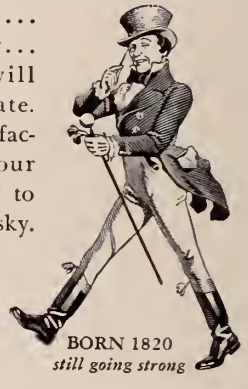


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Warren Renews Plea for Health Legislation

Sacramento, June 2.—Hard on the heels of the Legislature's enactment of the hotly controversial administration budget and tax reduction bills, Governor Earl Warren renewed his plea for health legislation today.

With budget and tax bill passage pointing to adjournment of the Legislature in three weeks or less, Warren urged consideration of a bill which would provide for hospitalization insurance.

The Governor outlined his views in a special message to the Legislature.

Warns of State Rule

In a last hour attempt to shatter Assembly opposition to the proposal, Warren told lawmakers:

"Unless steps are taken to break down the economic barrier between the family and the hospital, future expansion (of hospitalization) will undoubtedly be in the direction of public hospitals and staffs.

"This will lead to the growth of the very kind of State medicine we are trying to avoid."

Out of every 1,000 Californians, Warren said, 105 will need hospital care in any given year.

Disaster Threatens

"No family can tell from day to day whether or not, or when, or how often, some member of the family will fall within this group.

"This unpredictability, coupled with the increasingly elaborate and expansive nature of hospital service, constitutes a real risk and too often a real disaster for ordinary families."

Warren said the hospitalization insurance system would

(Continued on Page 46)



ERYSIPELOID
(Rosenbach's Disease)

Not to be confused with streptococcic erysipelas, this extremely painful, and sometimes even fatal infection is caused by Erysipelothrix rhusiopathiae. It is observed rather frequently among those brought into contact with animals and fish. Veterinarians, slaughterhouse-workers, butchers, farmers, bone-button makers, fish-handlers and cooks are most likely to contract the condition, which usually starts as an erythema at the site of primary infection, notably the fingers.

Now—WELL-TOLERATED TREATMENT WITH *Concentrated* ANTI-ERYSIPELOID SERUM

(PITMAN-MOORE)

HOW SUPPLIED

Pitman-Moore Concentrated Anti-Erysipeloid Serum is available in 10 cc. vials. Two to five cc. is usually adequate for the initial dose. In some instances repeated or increased dosage will not be necessary.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Since the disease in animals responds to sero-therapy, the unrefined anti-swine erysipelas serum was employed in human cases, with much success. However, this unconcentrated serum, in effective dosage, leads rather frequently to anaphylaxis and serum reactions.

REDUCED REACTIONS—To minimize this objection, Pitman-Moore Laboratories have developed a *concentrated* and *refined* antiserum for human use, in which the volume is reduced as much as 80%.

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WARREN RENEWS PLEA FOR HEALTH LEGISLATION

(Continued from Page 44)

lead to increasing the number of hospitals and their facilities.

Warren urged enactment of hospitalization legislation to place California in a position to obtain Federal funds.

Federal Plan Told

Congressional legislation, making millions available for hospital planning and development in the various states, is pending, he pointed out.

He termed lack of adequate hospital care for families "one of the most serious defects of our modern life."

Passage of the budget cleared the decks for consideration of special appropriation and "pork barrel" bills by the score, but only a comparative few have any chance of success.

The Governor is expected to sign the budget bill promptly without change, even though it totals $703,755,-145—highest in the State's history—and up $20,000,000 over the figure he originally submitted. . . .—San Francisco *Call-Bulletin*, June 2.

Gosselin's Fracture.—Many academic honors were accorded Leon Anthanase Gosselin in his lifetime. After medical studies that included instruction under Roux, Blandin and Velpeau, he became a surgeon at various Parisian hospitals, and then, in 1867, at the "Charité." He was elected a member of the Academy of Medicine in 1860, and in 1867 succeeded Velpeau in the Surgical Clinic. In 1874, he succeeded Nélaton at the Academy of Sciences.—Warner's *Calendar of Medical History*.

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★ **THE EFFECT OF PENICILLIN ON RHEUMATOID ARTHRITIS**—Proceedings of the Staff Meeting of the Mayo Clinic

★ **PROBLEMS OF TREATMENT OF TROPICAL DISEASES IN RETURNING MILITARY PERSONNEL**—New York State Journal of Medicine



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Indicated in combinations with Sulfa therapy

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GYNECOLOGY—Two Weeks Intensive Course June 18. One Week Personal Course Vaginal Approach to Pelvic Surgery July 9.

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Hospitalization Plan

Warren Urges Action on Health Bill, Minimizes Controversy on This One

Sacramento, June 2.—Governor Warren today appealed to the Legislature in a special message to enact his measure for a payroll hospitalization plan.

He invited the Legislature to amend the hospital bill if necessary to improve it, but asserted that the measure, tabled by the Assembly Public Health Committee, would provide a program for substantial progress toward improvement of health standards. He added it would not evoke controversy as had his proposal for a more comprehensive, compulsory health insurance system.

Governor Warren described the unpredictability of illness and the expensive nature of hospital service as "a real risk and too often a real disaster for ordinary families."

Other Measures

The health issue is one of the remaining keystones of the Governor's legislative program. The general tax reduction bill setting the State sales tax at 2½ per cent for the next two years and the $703,000,000 budget bill have been passed.

"We know from experience that out of every 1,000 population about 105 will need and use a hospital in a given year," the Governor's message said.

"Legislation within the principle of pending Assembly Bill 2201 would spread this risk among more than 2,000,000 employed persons in the State by a means of a payroll contribution of ½ of 1 per cent and similar contributions by their employers.

Under the plan, he added, the State's workers and their dependents would be assured payment for hospital costs

(Continued on Page 52)



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HOSPITALIZATION PLANS

(Continued from Page 50)

for a period of 30 days for each disability, covering about 98 per cent of all hospital cases.

Population Increase

He stressed that lack of city and rural hospital facilities would be emphasized in the postwar years, "when our State will have a population increased by more than 1,500,000, including about 800,000 war veterans." A stimulus to increased facilities, he added, would come from assurance of an income to justify enlargement of their services.

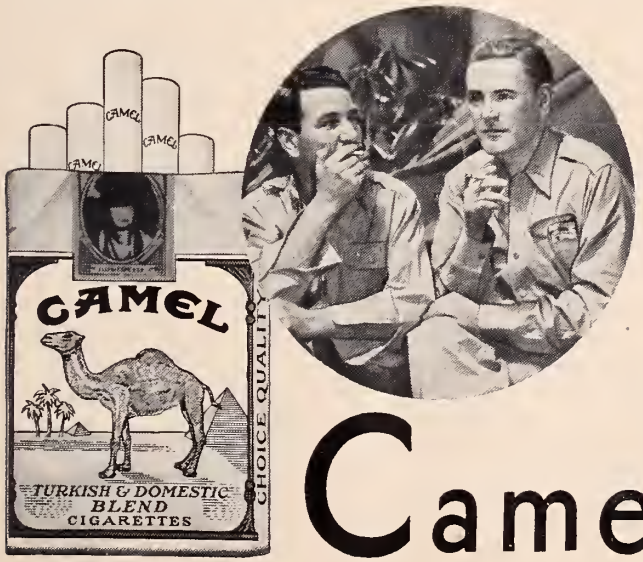
He said also that California should be prompt to place itself in a position to take advantage of the opportunity forecast in pending Federal legislation "to make millions of dollars available on a matching basis for hospital planning and development on the State level." . . .—San Francisco *Chronicle*, June 3.

Hirschsprung's Disease.—During the year 1888 was published the report on two cases of "Constipation in the Newborn as the Result of Dilatation and Hypertrophy of the Colon," which Harold Hirschsprung first presented in 1886. However, it was not until 1889 that he specifically described "Congenital Dilatation and Hypertrophy of the Colon." This article appeared in a "Festschrift" number, in 1890, in honor of the seventieth birthday of Edouard Henoch.—Warner's *Calendar of Medical History.*



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Laurence-Moon-Biedl Syndrome.—Compound eponyms usually give evidence of the long historical record that lies behind them, as in the case of the Laurence-Moon-Biedl syndrome. Briefly recalling the facts in the case, Laurence and Moon reported cases in 1866. They were not noticed particularly, however, until this syndrome was described once again by Bardet in 1920 and Biedl in 1922. The original Laurence-Moon account was revived in 1925 by Solis-Cohen and Weiss.—Warner's *Calendar of Medical History.*

Hospitalization Bill

Hot Debate Is Expected

Sacramento, June 3.—With the budget and tax reduction bills out of the way, the legislators this week looked forward to fireworks on Governor Warren's compromise proposal for a compulsory public hospitalization insurance bill.

The hospitalization bill may be discussed on the floor of the Assembly tomorrow, when Assemblyman Albert Wollenberg of San Francisco is scheduled to argue his motion to withdraw the measure from the Public Health Committee, which tabled the bill last week. . . .

Wollenberg will take the floor in behalf of the hospitalization bill with a letter from Warren urging favorable consideration. Observers held little hope the bill will fare any better than the Governor's original proposal for a compulsory public health insurance act. This bill and a similar measure proposed by the C.I.O. were frozen in committee.

That *a special session* on the subject will develop either next fall or winter is looked upon as a foregone conclusion. And if this fails, it is expected the matter will be submitted to the people at the November, 1946, general election as a *constitutional amendment.*

June 16 Adjournment

Predictions of adjournment by June 16 made this the last week in which the Assembly and Senate will consider their own bills. . . .—San Francisco *Chronicle,* June 4.



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1940—Alpha-Tocopherol Merck (Vitamin E) was made commercially available.

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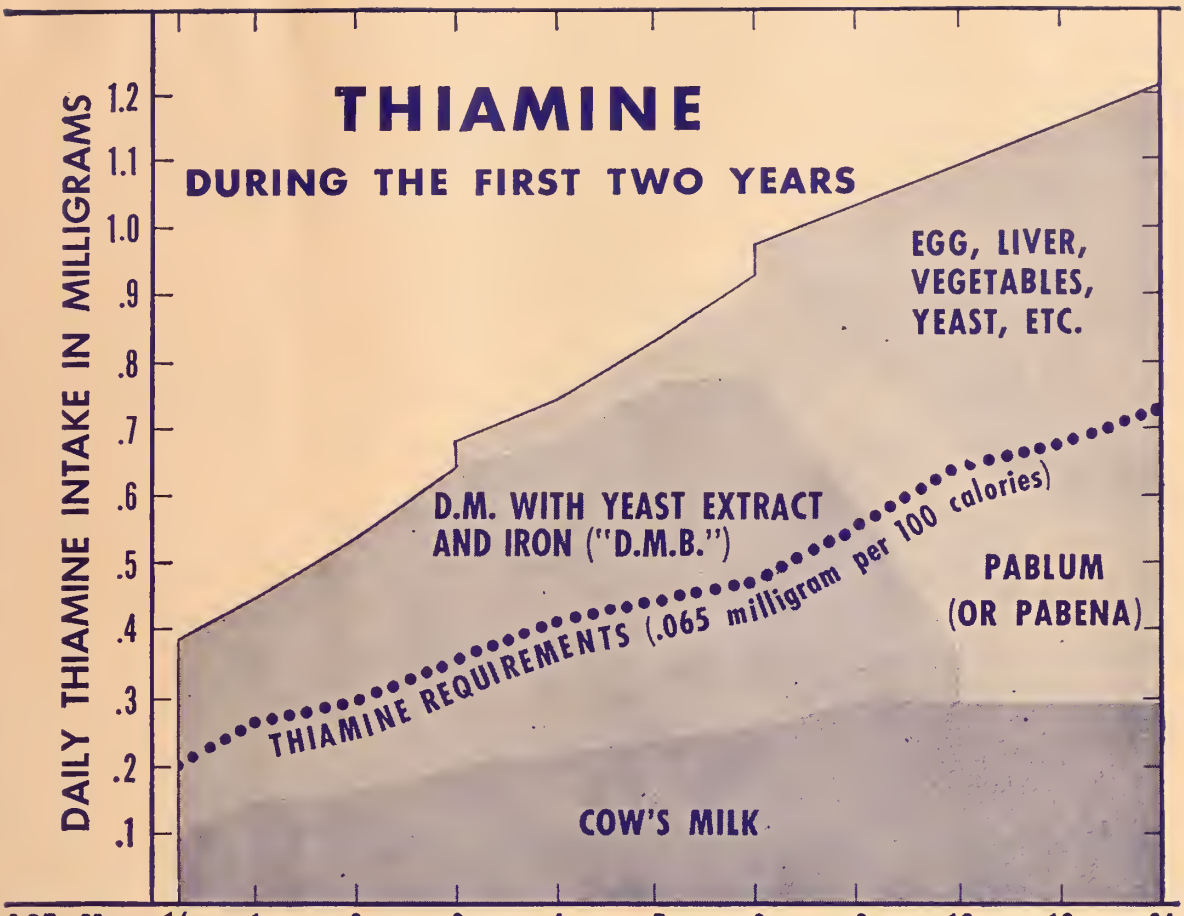


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